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## Rural Medical Practice: the landscape is sometimes bleak

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### this issue:

**Aid to rural health care**

*Legislative help in recruiting and retaining physicians in rural Colorado communities*

**"Please...no more letters! (about HIV testing of health care professionals)"**

*CMS President Harrison G. Butler, III, M.D.*

**CMS Policy on HIV Infected Physicians**

**"On Being A Doctor"**

*Resident in the throes of a patient's death*





# Goals Vs. Performance



**1981 Goal:**  
Operate Not-For-Profit

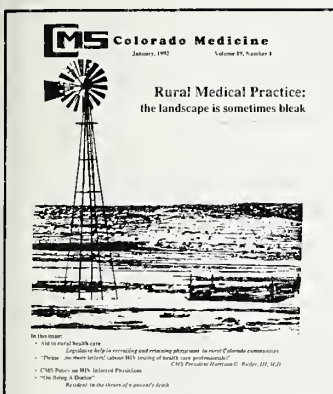
**1992 Assessment:**

The 1980-81 CMS contract with a national carrier contained a 7.5 profit load in calculating premiums, Copic books no such profit load. We return all "profit" to policyholders in rate-making and/or distributions.



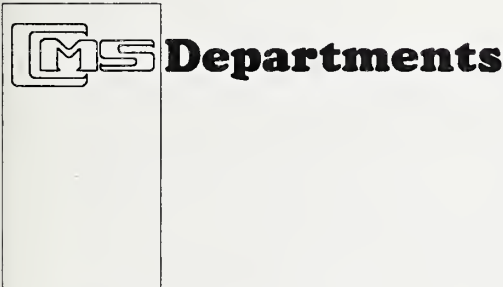
**The bottom line for Copic:**  
provide Colorado physicians and, indirectly, the people of the state with professional liability insurance which is affordable, equitable and fair.





## Cover Story

The winds of change blow through a sometimes bleak landscape. Those who can learn and adapt will survive the plethora of changes in medical practice and be better physicians.



- 5 President's Letter
- 7 Executive Director's Report
- 16 Colorado Department of Health
- 21 Specialties
  - Colorado Gyn/Ob Society
- 22 Medical News
- 25 Classified Advertising

## In This Issue...

- 5 President Butler says, "No mandatory AIDS testing"  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 8 On Being A Doctor—Dealing with a patient dying of AIDS  
*by J. Randall Curtis, MD,*  
*Seattle Veterans Affairs Medical Center*
- 10 Policy on HIV Infected Physicians
- 13 Domestic Violence Education—A Priority  
*by Constance M. Platt, PhD*  
*Colorado Domestic Violence Coalition*
- 14 Rural Health Care Gets a Boost
- 19 Death Certificates—Are you doing a good job?

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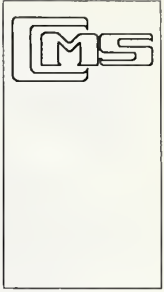
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***“Please...no more letters! I don't like the word “mandatory” any more...”***

Out of the many important activities performed by your Medical Society, two issues are consuming a great deal of time and energy of the Society. Those two issues are the implementation of the RBRVS and the controversy surrounding HIV.

As a service to the physicians of Colorado, the Colorado Medical Society is touring the state giving seminars on the changes in coding that will be required when billing Medicare after January 1, 1992. Edie Register and Lynne Northcutt have become the best informed people in the state on RBRVS coding. I attended the seminar given by Lynne when she was in Durango, and it was excellent. It is obvious to me that the physicians must become more involved in the **onerous** task of coding. Your office staff simply will not have enough information to code accurately without considerable more physician input. As an aside, I can't think of many things I consider to be a greater waste of my time than the care and feeding of an inefficient and self-serving bureaucracy, but such are the times in which we live. A plea from your President is to remember that the Bush Administration has demanded the implementation of this system, not Lynne or Edie, so be gentle with them. They are simply the messengers trying to help!

The CMS is also vitally interested in your comments about problems you encounter with the RBRVS as we will continue to have input into HCFA

through our Congressional delegation as this process goes on.

The second issue is HIV. There has been renewed interest in mandatory testing of physicians and health care workers after the death of Ms. Burgalis and the revelation of an HIV-infected Colorado pediatrician. This problem continues to be discussed at an emotional, rather than a factual level.

In order to get a better understanding of the thoughts and feelings of the membership, a survey on HIV will be mailed shortly. Please fill out and return the survey to us. What you are thinking is extremely important to me! The results of the survey will be used in several important ways: first, to more completely define the position of the Colorado Medical Society on the several issues surrounding HIV; second, the committees of CMS will use the results to help formulate and monitor legislation; third, we will develop patient and media education information that will be widely disseminated,

hopefully to cast more factual light on HIV.

It is interesting to note that we cannot find any other survey done of membership of a state or national physician organization, with the exception of a survey done of the Denver Academy of Surgery membership. However, they voted not to release the results of the survey.

As you can see, this survey is very important. So again, please respond.

Finally, being your President is interesting, fun and stimulating. However, there continues to be a misunderstanding as to my stance on HIV testing of physicians. I am for testing of HIV and HBV for physicians, but on a voluntary basis. Please, no more letters. I don't like the word “mandatory” any more than anyone else. I'm sure, however, that proposed legislation (not proposed by CMS) that we will be forced to deal with is not as charitable. Further, if we go on record as having a policy of voluntary testing, our position can be defended with more vigor than if we simply stonewall at the legislature. I prefer the pro-active position.

Next month, the Colorado General Assembly convenes, so no telling what will happen. However, I can assure you that the CMS will be “on top of it.”

Best wishes for the new year.

# AIM HIGH



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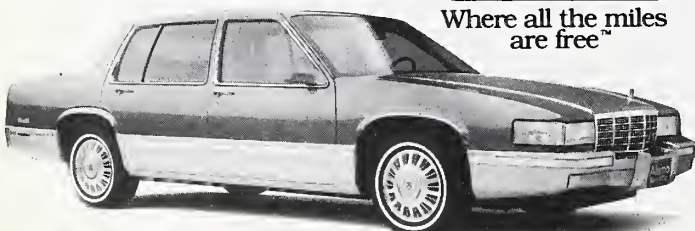
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# Executive Director's Report



*Sandra L. Maloney  
Executive Director  
Colorado Medical Society*

To Colorado Medical Society members:

The past year has brought many changes to CMS. Your medical society continues to work to accomplish its mission of being "Colorado's leader in advocating excellence in the profession of medicine and in the provision of medical care." Your support, help and contributions will continue to make this a strong and viable organization.

Following is a brief summary of where we have been, how we are organized, and some of the past year's highlights.

The Colorado Medical Society (as a professional society) was founded in 1871 in the Colorado Territory. Today, CMS represents approximately 4400 (or 67%) of the practicing physicians in the state and is the only statewide organization representing a cross section of physicians.

During the past 12 months CMS completed another successful financial year. Again, we received a good report card from the certified audit. And again, the auditors made no adjustments. After restructuring from the \$4 million building loss, CMS was able to start fiscal 1992 with over \$100,000 in net worth. We are on our way toward rebuilding financial health and independence! In addition, CMS received another four-year term for our accreditation efforts in continuing medical education.

As you are likely aware by now, CMS has relocated in its new leased space at 7800 E. Dorado Place in the Copic building; however, it will be a while before everything is unpacked and we are completely at home.

The Annual Meeting at Snowmass was a great success, highlighted by the CMS (M\*A\*S\*H party) salute to returning military, and the keynote address by United States Inspector General Richard P. Kusserow. Next September we will be meeting at Copper Mountain.

By the time you read this you should have received the HIV survey mailed to all members in early January. If you haven't already done so, take the time to complete the questionnaire because we need your opinion.

As reported last month, CMS recently endorsed and became the sponsor of the Respiteer™ respite care program, aimed at providing relief for the family member (or other similarly affected person) who is effectively homebound caring for an aged and/or disabled household member. We are very excited about this program and look forward to a long and fruitful relationship.

Last month's *Colorado Medicine*, included information regarding Advance Directives, along with sample forms. Don't overlook this latest Washington reg. With an ever-growing aging population, most primary care physicians will eventually be impacted by Advance Directives.

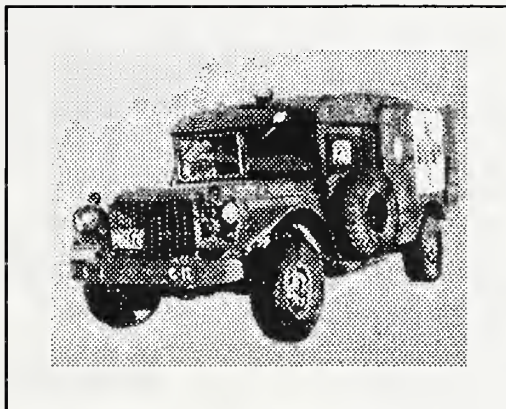
Probably the most difficult and frustrating issue to deal with has been RBRVS and the changes effective January 1, 1992. As you know, CMS (in conjunction with the Medicare carrier) has blanketed the state with seminars during December explaining and providing as much up-to-date information as possible to help alleviate problems.

This issue contains a center pull-out concerning Colorado's 58th General Assembly, which convenes in early January. We've said this for a number of years, but each year

becomes increasingly critical to fee-for-service practice. Your help and your input is needed during this session, so use this special publication from the Legislative Council.

Our delegates and alternates to the American Medical Association recently attended the AMA Interim Meeting. We welcome to our delegation two new alternate delegates; Drs. Joel Karlin and Robert Bogin. Unfortunately, we lost Dr. Robert Sawyer as a delegate. His absence has been noted by physicians, nationwide. Members of the CMS delegation to the AMA will be reporting more on the current issues.

Hope you all had a safe and pleasant holiday season.







# n Being A Doctor

*Editor's Note: Hopefully, more and more lay people are finding that it is even difficult for physicians to deal with and accept the inevitability of the death of a patient; there's a longing, a sadness, even a period of mourning through which the doctor must live and continue to function for the other patients still entrusted to the doctor's care. But this sadness persists no matter how much the doctor tries to hide it and remain impassive.*

*This is particularly true in the new era of seeming irreversibility of AIDS infection. As a non-physician I have watched, and felt, what the physician must have to go through in such ultimate care. My feeling over the years is that being a physician is not just the science of the profession; it goes far beyond—even so far as my knowing that my doctor is also a good friend. As many have said, "medicine is not a perfect science," but each physician must not be expected to personally bear the imperfections. This story touched me because the physician is able to come to grips with the "ultimate" efforts, knowing that the patient, more than anything else in the world at that moment, needed the comfort of a friend to the last. The resident in this story realizes that a physician's job may be well done despite the patient's death.*

**Bill Pierson**  
Managing Editor

*Reprinted with permission from the Annals of Internal Medicine, 1991; 115:823-824.*

## Job Well Done

Sitting here in the intensive care unit, waiting quietly while friends and family gather around the bedside to say their final good-byes to Paul, I find myself staring blankly out the window. The mechanical whir of the ventilator and the cold December rain on the window help me to drift peacefully back over the last two and a half years.

Paul was 23 years old when he and I first met. It was a warm July day in Seattle. I was in the first month of my internship, and it was Paul's first visit to my clinic. He had been healthy all his life, until the previous month when he landed in the hospital with bacterial pneumonia. He did well, spending only 36 hours in the hospital, and was referred to my clinic for follow-up care. As I rounded the corner to the examination room, the first I saw of him was his black, pointed-toe suede boots propped up on my desk. When I introduced myself, standing formally with right hand outstretched, he slipped his feet slowly off the desk, put his *Rolling Stone* magazine in his canvas shoulder

bag, and offered his hand, but didn't stand. I felt the contrast between his floppy blond curls hanging down around his round gold-rimmed wire glasses and my close-cut carefully combed brown hair; his oversized gray sweat shirt and my shirt and tie. Yet I remember feeling put at ease by his warm smile and attentive blue eyes. Because his medical history was short, we had plenty of time to cover non-medical issues. He worked as a chef at a local restaurant but wanted to open a restaurant of his own in a few years. His restaurant was going to be such a success that he would be able to open a new one every time he felt ready to move to a new city. His last restaurant was going to be on one of the San Juan Islands where he and his lover would retire.

He seemed very comfortable telling me he was gay but added quickly that he had practiced safe sex since 1982 and had been in a monogamous relationship for the last 5 years. He had never had an HIV test, mostly because he didn't think he was at high risk. I talked him into having HIV serologic testing. Much can be done these days—even before any symptoms appear, I remember saying. I expected the results to be negative but wanted to be reassured because of his recent pneumonia.

He returned a week later. I greeted him cheerfully in the hall and went off to find his chart while a nurse put him in an examination room. When I found his chart and his HIV results, I had to sit down alone for a few minutes to collect my thoughts. I hadn't received any training on how to tell a 23-year-old that his dreams and hopes may have to take on an entirely new time frame: that he would probably never own a restaurant or retire in the islands. I remember hoping that he wouldn't break down and cry in my office—

more for my sake than his. I also remember wanting to let him place his hope in the possibility that the test was wrong, but that didn't seem fair. Somehow we both got through that next half hour.

Over the next two years, Paul and I saw a lot of each other. There were spells when we saw each other once a week. Often he would come to clinic just to express his fears and anxieties; his friends and family sometimes found it difficult to listen to his anguish. Most of all, he feared the loss of freedom that he'd seen bedridden friends experience. At first, I would try to hide my discomfort when he talked about being afraid or when he cried. With time, I learned to listen without withdrawing or trying to talk him out of his pain. Eventually, I gave him my home phone number and he would sometimes call me there with urgent questions or simple worries.

He called me at home about a year ago; a close friend had died several days earlier and Paul had just returned from the memorial service. Paul called, he said, to ask me about some sores in his mouth. The pauses in his conversation made me suspect that the mouth sores were not his main concern. When I asked about his friend, he told me a story of a carefree young artist with progressive dementia, many of whose friends had pulled away in the last weeks. Paul resented those friends, his friends, who had stopped going to the hospital to meet the unrecognizing eyes and to hear the incoherent rambling, his anguish and sense of futility grew. He would dread each visit and then would chastise himself for his feelings. At first I tried to ease his guilt, but when my

words met with a cool reception, I realized that wasn't what he wanted. Instead, I listened. The next time I saw him the crisis had passed and the mouth sores had healed. Paul thanked me more for the mouth rinse than for the time we had spent talking, but it wasn't the mouth rinse prescription that made me feel most like Paul's doctor.

Paul called me at home 3 weeks

*“I talked in percentages and survival rates;  
Paul talked in time left to be with friends.”*

ago to tell me that his usual low-grade fevers were now up to 102 degrees and that he was having trouble catching his breath. I admitted him that night, and he hasn't been home since. Once in the hospital, he seemed to get worse quickly. It wasn't long before Paul and I had to talk about intubation. Even then, Paul had a sharp mind and a knack for asking questions for which there were no answers. I talked in percentages and survival rates; Paul talked in time left to be with friends. Finally, we decided we would intubate him if we had to, but he made me promise that if the outlook became dismal, we would make him comfortable and turn off the machines. Two days after his decision, he was intubated.

There was a flurry of activity about Paul's bed for his first few days in the ICU; Consulting residents, fellows, and attendings came and went. Their experience and their technology were called into action, but, in Paul's story, it was the disease that was most persistent. The consultants have since drifted away—in part because they had little left to offer.

The outlook is dismal. He has been intubated for almost 2 weeks. I can't talk to him any more, but he writes some and still has those crystal clear blue eyes.

Sitting here in the ICU, staring out blankly at the drizzling gray sky, I realize that I feel content. I'm sad, although perhaps not as sad as I was that day when I saw Paul's HIV results and felt an iron door slam shut on his future. Sad, but also proud of my role in Paul's life. I couldn't save his life, but I worked hard to give him as much time as possible. Not time spent exhausted and unable to get out of bed, but time to be with friends, to enjoy a breeze, or to cook a meal. When his last infection came, I acted quickly and aggressively in hope of giving him more time. But now it is clear that this is not the type of time we were fighting for, and I am prepared to stop. Not to stop giving my support and comfort. Not to stop spending time with Paul. But to stop trying to prolong his life. To some, this would be a failure. To me, for better or worse, this was a job well done.

*J. Randall Curtis, MD*  
Seattle Veterans Affairs  
Medical Center  
Seattle, WA 98108



# Policy on HIV Infected Physicians Adopted by CMS Board

This nation continues to struggle with the unresolved issues surrounding HIV infection and its routes of transmission, not all of which are clearly understood by the public. There is widespread fear, bordering on hysteria, that a health care worker could transmit the virus to a patient. The Colorado Medical Society shares this concern along with our Centers for Disease Control (CDC) and our Colorado Department of Health.

There is no evidence of transmission of the HIV virus from a medical doctor to a patient. Indeed, the evidence is just the reverse, health care workers have been infected from patients, though even this is extremely rare. Numerous "look back" studies on patients who have been cared for by HIV positive physicians fail to show any evidence of transmission. The widely reported case of the Florida dentist, Dr. Acer, is an anomaly with no clear explanation. Nonetheless, it is a cause for concern, and cannot be dismissed.

The Colorado Medical Society asked Senator Dottie Wham to convene representatives from the State Health Department, all appropriate specialty societies, dentists, Board of Medical Examiners, and other interested experts to develop an HIV Infected Health Care Workers policy which would implement the Centers for Disease Control Guidelines. The CMS Board has adopted these policies and requests that physicians study the policy outlined below.

## Colorado Department of Health HIV Infected Health Care Workers October 21, 1991

### Statement of the Problem:

Until recently the concern of HIV infection in health care workers (HCW) has been that the HCW would acquire the infection from the patient. However, the discovery of 5 infected patients related to a Florida dentist in 1990-1991 has brought to the public's attention the risk of the patient acquiring HIV from an infected HCW. HCW-to-patient transmission of hepatitis B, a virus that is epidemiologically similar to, but more infectious than HIV, has been demonstrated infrequently in the past. The risk of HCW-to-patient HIV transmission appears to be several orders of magnitude less than for hepatitis B and, thus, is extremely small. Such risk would occur during the course of invasive procedures in which the HCW's hands were in contact with a mucosal surface or body cavity, i.e. basically, during surgery or in the oral cavity. Exposure would occur if the HCW had weeping skin lesions on his/her hands or if the HCW cut him/herself and the integrity of barriers (such as gloves) was breached.

The Department of Health accepts the Centers for Disease Control "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures" [MMWR July 12, 1991; Vol 40; RR-8] and will adapt these recommendations for use in Colorado based on applicable state statutes and regulations. The Department will review HIV-infected HCWs on a case-by-case basis to determine if there is a potential danger to the public health.

The Department of Health recommends that all HCWs should adhere to universal precautions, including appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments. Further, HCWs should also comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures. The Department views prevention of patient-to-patient transmission via contaminated instruments as a public health strategy that will protect far greater numbers of persons from illness than focusing excessive attention on a small number of HIV-

*Continues on following pages...*



infected HCWs.

The Department of Health is opposed to mandatory or universal testing of either HCWs or patients. Such testing will provide a false sense of protection to the public and to HCWs, would be expensive, and could lead to non-scientifically based discriminatory actions. The Department supports development of a system to provide career counseling and job retraining for those HIV-infected HCWs whose practices are modified because of the HIV or hepatitis B infection status.

### CDH Protocol

This protocol is based on published recommendations of the CDC entitled "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures" (MMWR 1991; Vol 40; RR-8). As more information concerning the risk of HCW to patient transmission of HIV and hepatitis B becomes available and as public policy on this matter evolves, this protocol will necessarily change. Therefore, the following protocol should be viewed as preliminary and evolving.

1. Review Department of Health Registry for reported cases of AIDS and HIV infection to identify HCWs.
2. For all newly reported cases of AIDS and HIV infection, determine if occupation is HCW.
3. Determine if an infected HCW is a surgeon, obstetrician/gynecologist, family practitioner, emergency room physician/practitioner, dentist, or any other type of practitioner who might perform exposure-prone invasive procedures.

An October 7, 1991 "Dear Colleague" letter from William L. Roper, Director of CDC, stated that CDC is considering the following as general categories of exposure-prone procedures: intra-abdominal and colorectal surgery; intra-thoracic and cardiac surgery, major orthopedic surgery, major gynecologic surgery, caesarian deliveries and vaginal deliveries requiring suturing, and surgery in the oral cavity. Dr. Roper listed as examples of procedures that are not considered exposure-prone: phlebotomy; administering intramuscular, intradermal, or subcutaneous injections; needle biopsies, needle aspirations, and lumbar punctures; cutdown procedures; endoscopic, laparoscopic, bronchoscopic, and arthroscopic procedures; and placing and maintaining peripheral and central intravascular lines, nasogastric tubes, endotracheal tubes, rectal tubes, chest tube, and urinary catheters.

Based on the CDC recommendation that "Currently available data provide no basis for recommendation to restrict the practice of HCWs infected with HIV or HBV who perform invasive procedures not identified as exposure-prone" [MMWR 1991: Vol 40; RR-8 page 5], the Department will assume negligible, insignificant risk to patients by any HCW not performing exposure-prone invasive procedures.

4. For the infected HCWs determined by No. 3 to have practices which include performance of exposure-prone invasive procedures, the Department will investigate to determine:
  - a. date of diagnosis of HIV infection (date of + test);
  - b. (estimated) date of infection;
  - c. current medical status (immunologic, dermatologic, hematologic, neurologic, and pulmonary);
  - d. current medications;
  - e. whether the HCW has performed exposure-prone (as defined by CDC in MMWR 1991; Vol 40; RR-8; page 4) invasive procedures during the time interval when he/she could have been infected with HIV, and if yes, the type and number of procedures performed;
  - f. any instances of the HCW having had cuts/skin lesions while performing invasive procedures;
  - g. infection control/disinfection/sterilization procedures, whether these procedures are documented, and whether there have been any breaks in procedures;
  - h. location and availability of office records of the HCW
  - i. willingness/consent to cooperate with Departmental investigation;
  - j. availability of blood specimens for DNA sequencing analyses.

The information collected by this investigation will be treated as public health records covered by the confidentiality provisions of C.R.S. 25-4-1404(1).

5. If the answer to either No. 4(e) or 4(f) is affirmative, the Department will convene an expert review panel to provide advice to the Department/Executive Director. In addition to the State Epidemiologist and appropriate staff from the Division of Disease Control and Environmental Epidemiology, the panel might include all of the following: an infectious disease specialist, the HCWs personal physician, a practitioner with expertise in the procedures performed by the HCW, a neurologist, and an attorney familiar with state and federal civil rights/anti-discrimination laws. The identity of the infected HCW will not be disclosed to members of the panel unless the HCW voluntarily discloses this information on his/her own initiative, in which case the panel members must explicitly recognize the

importance of the privacy rights of the HCW. The HCW and/or the HCW's attorney may meet with the panel to offer information or respond to questions or information presented to the panel by staff of the Department. The expert review panel will make recommendations on whether the HCW's current practice represents a risk to patients and if yes, how to counsel the HCW regarding:

- a. whether to modify the practice, i.e. not perform certain invasive or exposure-prone procedures;
- b. whether to modify infection control/disinfection/sterilization procedures in the practice;
- c. how frequently there should be medical evaluation;
- d. if there is need to inform patients (past or future):

Notification of at least certain patients would be undertaken if (1) patients are known to have been exposed to an infected HCW's blood (or other body fluids to which universal precautions apply) via a percutaneous, mucous membrane, or cutaneous contact or (2) transmission of HIV from the HCW to one or more patients is documented.

Notification may be considered if there is evidence of (1) medical conditions which would significantly impair the HCW's ability to perform procedures and/or increase the risk of patient exposure (e.g. dementia, encephalopathy, certain neuropathies, exudative lesions or weeping dermatitis of the hands), and/or (2) serious breaches in standard infection control practices designed to reduce blood born pathogen transmission.

Notification may be selective, i.e. restricted to patients undergoing exposure-prone invasive procedures during the period the HCW had a serious medical condition or when a break in standard infection control occurred.

Precautions will be taken to assure confidentiality of the HCW and patient information to the fullest extent.

- e. what is the best way to monitor the HCW's practice for compliance with the recommendations;
- f. how frequently and under what circumstances the panel should meet to reconsider the case.

All reports, minutes, or written comments of the expert review panel will be treated as public health records covered by the confidentiality provisions of C.R.S. 25-4-1404(1).

6. The Department will use the Panel's recommendations to determine how it will counsel the HCW. The decision on counseling rests with the Department. The Department will monitor the HCW's voluntary compliance with the counseling message.
7. If the HCW disagrees with the Department's recommendations, the matter may become a mandatory proceeding in which, pursuant to C.R.S. 25-4-1406, the Department would issue a public health order and the HCW may challenge the order in a judicial proceeding.

## Legal Duties and Authority of the Health Department

C.R.S. 25-4-1405(1) states "It is the duty of state and local health officers to investigate sources of HIV infection and to use every proper means to prevent the spread of the disease."

C.R.S. 25-4-1406 consists of the public health administrative and legal procedures for dealing with persons with HIV infection who pose a danger to the public health. The statute states that if the executive director of the state department of health knows or has reason to believe, because of medical or epidemiologic information, that a person with HIV infection is a danger to the public health, the executive director may: (1) issue a public health administrative order to require the person to undergo counseling on HIV infection and how to prevent transmission of the virus; (2) issue an order to cease and desist conduct which endangers others if the person has received counseling but continues to demonstrate the endangering behavior; and (3) for a person who violates a cease and desist order, issue an order in effect for up to 90 days restricting the conduct which endangers others. Restrictive orders may include required participation in evaluative, therapeutic, and counseling programs. At each step in the process of C.R.S. 25-4-1406, i.e. after issuance of public health administrative orders, the person subject to the order may refuse to comply with the order and seek a judicial hearing.



# Domestic Violence Support

by Constance M. Platt, PhD  
Colorado Domestic Violence Coalition

The Domestic Abuse Assistance Program—The DAAP Tax Check Off—enables Colorado taxpayers to support shelters and crisis lines in communities all over the state by checking off a contribution on their state income tax.

The American Medical Association and the Colorado Medical Society have made domestic violence education a priority for this year, both for the public and the medical profession.

## Education a Priority

Not only do DAAP agencies serve battered women and their children, they educate their communities about an insidious kind of abuse: violence against elders.

As the number of elderly people in our population grows and as social services are cut, more older people are forced to turn for care to families that may already be burdened.

Only about 6 per cent of elderly people are cared for in nursing homes. 30 per cent live alone, while 63 per cent live in families, where the greatest risk of elder abuse occurs.

The shelters and crisis lines that receive donations from the DAAP fund are fully informed about local sources of help for elderly people who suffer physical harm, psychological abuse or financial exploitation at their relatives' hands.

## The Problem Can Be Underestimated

Isolated and often ashamed, elderly people are unlikely to report psycho-

## Domestic Violence Education—A Priority

logical abuse and neglect, the most common form of elder abuse. However, the local shelters' efforts to publicize the program and sources of help for struggling care takers may sensitize friends or neighbors and encourage them to intervene. The interests of domestic violence workers and medical personnel complement each other.

Three out of four abused elders are female, and the older and more depen-

dent the woman, the more likely she is to be abused. Workers trained in dealing with domestic violence are skilled at reaching out to the victimized women.

Colorado is one of only three states in the nation that does not provide money for domestic violence programs, so your contribution to the Domestic Abuse Assistance Program extends help to victims of abuse state wide.

For more information about elder abuse, phone the Elder Abuse Prevention Project (303) 293-8100 or Colorado Domestic Violence Coalition (303) 573-9018.

## Domestic Violence Training

The Colorado Department of Health's Family Violence Prevention Program and the Colorado Domestic Violence Coalition are taking domestic violence training to health care providers in rural communities.

Training sessions were offered in Grand Junction and Cañon City in November, and others will be held in Boulder in January, Colorado Springs in February, Yuma, Fort Morgan and Sterling in April and Montrose, Delta and Gunnison in May. Funding from the Colorado Trust makes this possible.

Health care providers were taught how to identify victims of domestic violence and how to respond to them in a manner which both builds trust and encourages them to seek help. Providers also learn about community resources and extensive training manuals are provided. (Denver's Porter Hospital paid for the printing of the manuals.) Nearly 700 people received such training last year. Domestic violence is the most common, yet least reported crime in the country. In Colorado in 1989, 20,000 domestic violence arrests were made and close to 72,000 crisis calls were made to shelters.

The program also offers an optional one hour introductory session at hospitals for physicians and nurses. For further information, contact Deborah Haack in the Division of Prevention Programs at (303) 331-8293.



# R

## ural Health Grants for Colorado

*Current information compiled by  
Colorado Medicine staff*

Three separate federal grants awarded to the Colorado Department of Health, the Colorado Hospital Association and the University of Colorado Health Sciences Center will go a long way toward improving access to health care in rural areas of the state, according to Dr. Richard Call, President of the Colorado Rural Health Consortium.

The Consortium represents more than 25 organizations involved in rural health care.

"We have struggled more each year to provide adequate health care in rural Colorado," says Dr. Call, "But it's difficult to recruit doctors and other health care professionals because rural earnings are far below those of city counterparts and many new practitioners have overwhelming education debts.... The average debt upon graduation from medical school is more than \$45,000. By the time residencies are completed, the debts are even greater."

The three grants are:

1. **The Colorado Health Professions Loan Repayment Program.** This program creates a fund of federal and local dollars to repay student loans for those physicians, dentists, nurse practitioners, physician assistants, certified midwives and mental health workers who agree to practice in underserved rural areas. Administered by the University of Colorado Health Sciences (under the

*The average debt  
upon graduation from  
medical school is  
more than \$45,000.*

Statewide Educational Activities for Rural Colorado Health/Area Health Education Centers (SEARCH/AHEC) program), the loan repayment program was authorized by the Colorado legislature and initiated by a \$200,000 loan from the CU Foundation, the fund raising arm of the University. As communities recruit health care providers, they will use funds from the \$200,000 loan and matching federal funds to pay the educational loans of their recruits. Then they will deposit the "community match" back into the loan fund to continue the program. Of Colorado's 63 counties, 37 have health care manpower shortages. At least 10 to 15 communities will be able to take advantage of the program each year to obtain new physician and other health services, said Dr. Call, who is also SEARCH director. (See following page for more information on the requirement process for this program..)

2. **Colorado Rural Health Resource Center.** The National Center for Rural Health Policy awarded a three year \$115,000 grant to the consortium

to start a Colorado Rural Health Resource Center. Housed initially in the Colorado Department of Health, this Center will serve as a central clearinghouse for information on rural health resources and will ensure cooperation and resource sharing among Colorado's many underserved rural communities.

3. **Colorado's Rural Health Network Development Program.** Colorado was one of seven states awarded federal funds to improve access to medical services. The \$241,739 was granted to the Colorado Department of Health and the Colorado Hospital Association. The program will help small rural hospitals convert to a new type of limited service (six beds or fewer) health care facility or a "Rural Primary Care Hospital." Patients will be stabilized and treated in the rural primary care hospitals, then transferred if necessary within 72 hours to the more fully equipped "Essential Access Community Hospitals." The program will also improve the network for required emergency care.

In the first phase of the grant, a task force will determine which community facilities will be designated as primary care hospitals and essential access hospitals.

For more information, call the Colorado Department of Health at 331-4611, Colorado Hospital Association at 758-1630 or the University of Colorado Health Sciences Center at 270-5571.



## 1992 Colorado Health Professions Loan Repayment Program

The 1991 Colorado General Assembly passed legislation to assist medically underserved communities in the recruitment and retention of needed health care providers. This legislation [The Colorado Health Professions Loan Repayment Program (CHPLRP)] was sponsored by the University of Colorado health Sciences Center in conjunction with the Colorado Department of Health and the Colorado Community Health Network. Under the law, at least 20 communities per year will be assisted through repayment of the educational loans of primary care physicians, dentists, nurse practitioners, and certified nurse-midwives who agree to practice in federally-designated Health Professional Shortage Areas (HPSA). There are, however, stipulated federal requirements for communities as well as the health care providers, in order to participate in the program. This program is to be administered by the UCHSC's Statewide Educational Activities for Rural Colorado Health/Area Health Education Center (SEARCH/AHEC) program, using matching loan funds provided by the National Health Service Corp.

In order to participate, community organizations must:

- Be a public or nonprofit private entity providing primary health care services in Colorado.
- Be within a federally designated HPSA for the provider being sponsored. If you are unsure if your community qualifies for this designation, contact Ms. Lindy Nelson of the Colorado Department of Health (303) 331-8346.
- Provide a community cash match

### *Rural Health Care Aid*

equivalent to one-half of the authorized loan repayment amount. This is paid to the Colorado Health professions Loan Repayment Program

- Assume responsibility for completion of timely annual reports concerning compliance with program requirements.

The provider must be willing to enter into a contractual agreement with the community nonprofit agency or public sponsor and the CHPLRP. This agreement requires the provider to

- Hold current license to practice as:
  - Physician

Family medicine (allopathic and osteopathic)  
Internal medicine  
General pediatrics  
Obstetrics and gynecology  
Psychiatry

- Physician assistants
- Dentist
- Nurse practitioners
- Certified nurse-midwives

- Charge for his/her services at the prevailing usual and customary rate. If a person is unable to pay such charges, the person may be charged at a reduced rate or not charged any fee.
- Not discriminate on the basis of the

individual's ability to pay for care or the source of payment. These payment sources may include Title XVIII or Title XIX of the Social Security Act. The provider must agree to accept assignment for payment under the Social Security Act.

- Practice full time in the designated area for a minimum of two years. This contract may be extended up to a maximum of six years.

The University of Colorado Health Sciences Center's SEARCH/AHEC program will be assisted in setting funding priorities by the Statewide Loan Repayment Program Advisory Committee.

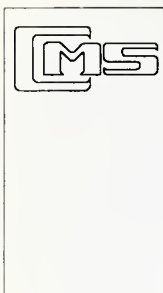
Awards will be granted quarterly based on the following criteria:

- The need for a particular provider in a community.
- The amount of loan repayment requested in relationship to the length of time the provider is willing to practice in the community.
- Other criteria that may determine the long-term success of the recruitment and/or retention effort.

#### How To Apply:

For the 1992 program year, applications must be received by your local AHEC office or the SEARCH program office by January 15, March 18, June 18, or September 16 for disbursement of awards at the end of the same months. Applications received for one quarterly review, but not funded, will be reconsidered, upon request, at subsequent quarterly reviews in light of competing statewide priorities.





# Occupational Health and Environmental Illnesses in Colorado

*by Sallie Thoreson, MS*

*Disease Control and Environmental Epidemiology Division  
Colorado Department of Health*

The health care community and the public are increasingly concerned about health effects from the toxic substances found in the working and living environment. The Colorado Department of Health (CDH) has several programs which focus on the surveillance and prevention of specific illnesses caused by occupational and environmental exposure to toxic substances.

These programs help address the goals of Healthy People 2000, the U. S. Public Health Service's national strategy for improving the health of the nation over the coming decade. The summarized goals for environmental health and occupational health and safety are listed in the informational box.

## Occupational Illnesses

Lung diseases are among the most common occupational diseases since the respiratory system is frequently the pathway of exposure for toxins. CDH has an occupational epidemiology program aimed at surveillance and prevention of work related asthma and hypersensitivity pneumonitis (HP). Beginning in 1988, physicians and other health care providers have been required to report diagnoses of work related asthma and HP to the health department.

Richard Hoffman, MD, MPH,

director of CDH's Disease Control and Environmental Epidemiology Division says, "Work related asthma is not pathologically different from non-occupational asthma. It differs only in that symptoms are provoked by agents in the workplace. The patterns of association with work can be varied. When a physician reports an asthma diagnosis that is thought to be work related, the health department can assist in establishing the workplace connection."

HP is a relatively uncommon respiratory disease in which the lung parenchyma, rather than the airways, are the site of allergic reaction. HP can occur in persons repeatedly exposed to organic dusts, animal or plant proteins, microorganisms, or certain low molecular weight chemicals. The illness can present in an acute, subacute or chronic manner and has been associated with various occupational groups including farmers, animal handlers and office workers employed in facilities with contaminated ventilation systems. HP is characterized by fever, myalgia, malaise and respiratory symptoms including chest tightness, shortness of breath, cough, coryza/runny nose. Specific clinical findings can aid in the diagnosis.

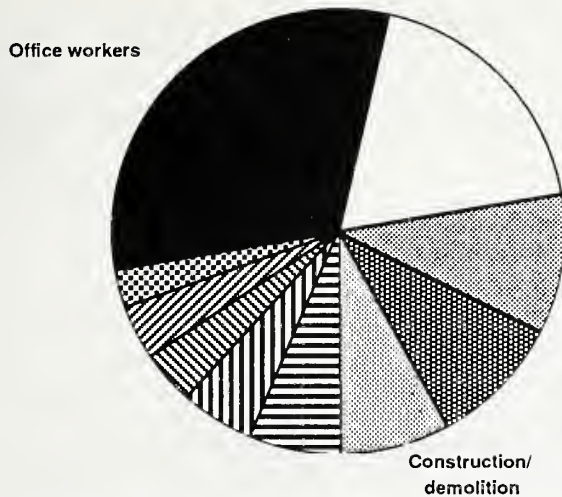
To date, the Occupational Epidemiology Program has collected 110

asthma and 45 HP reports. These reported cases reflect workers in 77 workplaces. Program activities have included 31 completed or ongoing worksite investigations. Reports from these investigations are widely distributed to workers, employers, unions and other interested health agencies. "Our intention is to investigate cases, to provide preventive services based on our findings and to disseminate the information to other occupational settings as appropriate," says Jane McCammon, Certified Industrial Hygienist and director of the Occupational Epidemiology program.

As shown in Table 1, the most frequently reported occupation for asthma cases has been the office worker. Many of these cases have been associated with work in "tight," mechanically ventilated buildings, i.e. the windows cannot be opened. Five cases were related to evaporative cooler use in one school district and have led to further study of the microorganisms found in these coolers. In one building, a person with both work related asthma and sarcoidosis was reported and follow up investigations have identified additional workers with respiratory illness. This has led to a survey of over 300 workers in the building to determine the prevalence of work related respiratory symptoms.



## Occupation of Reported Cases of Work Related Asthma January 1988 — June 1991



Examples of other occupations with single cases: Mining engineer, Printer, Medical lab technician, Photo lab technician, Carpet layer, Postal worker, Brewer, Computer assembly worker, Welder, Meat cutter, Florist, Taxidermist, Pharmaceutical worker, Sales clerk.

Twenty-nine of the asthma cases and two of the HP cases are related to exposure to isocyanates. Exposure has occurred in waferboard manufacturing, foam manufacturing, automobile painting, taxidermy and rubber manufacturing. CDH is continuing to study the respiratory health of workers in the two waferboard manufacturing plants in Colorado.

The reports of four asthma cases in cosmetologists has prompted a specific CDH study on the respiratory health of cosmetologists, cosmeticians, barbers

and manicurists in the state. A random exposure survey has been sent to 3,074 of these workers representing 10% of those licensed in Colorado. The exposures of concern are the acrylics and adhesives used in artificial nails as well as chemicals in hair coloring and hair treatment.

For work related HP cases, 45 have been reported and 34 of these cases have been reported in employees at one municipal swimming pool. Hoffman says, "This is the first known association of HP with an indoor swimming

pool. CDH has been part of the investigation into this health problem. The investigation has not identified a definite etiologic agent, but the pool's extensive use of water spray features clearly presents the potential for aerosolization of any chemical or biological contaminants in the pool water." Measures have been taken, or are in progress, to correct the ventilation system, to resurface the pool with ceramic tile, to contain the use of water features and to disinfect the water by ozonization. The pool has been closed since September, 1990.

## Environmental Illnesses

The Colorado Department of Health has had a historic involvement with environmental health through efforts to assure safe supplies of food and water, management of sewage and solid waste, and the control and prevention of communicable diseases. More recent programs include the monitoring and regulation of toxic discharges into the air, water and soil and the clean-up of hazardous waste sites in the state.

"Exposure to hazardous substances is of great concern to the public, their health care providers and public health officials," says Michael P. Wilson, PhD, chief of the Environmental Toxicology section. "One of the real challenges in environmental health is to examine the link between environment -

## Number of Reported Cases of Work Related Asthma by Occupation January 1988 — June 1991



See next page...

tal exposure and health effects. We are beginning to approach this aspect of public health through programs in heavy metal surveillance and exposure studies of populations near hazardous waste sites in the state."

Heavy metal exposure is of concern in Colorado due to the existence of numerous mining and milling sites, the potential for exposure from a variety of environmental conditions and the possibility of concurrent occupational exposure. Elevated levels of lead, arsenic, cadmium and mercury are reportable conditions in Colorado. "The heavy metal registries maintained by the health department help us to identify additional areas for education and prevention programs," says Wilson.

There are 16 federally identified Superfund sites in Colorado, with the addition of two sites considered

hazardous waste sites by the state. The CDH has been involved in exposure studies at five of the 18 sites. Funding for these studies has come from the federal Agency for Toxic Substances and Disease Registry (ATSDR), which is a part of the U. S. Public Health Service. Children in the mining areas of Leadville, Aspen and Clear Creek have been tested for lead, cadmium and arsenic. The studies have identified blood lead levels above 15 µg/dl in 15% of the Leadville children with far fewer children at risk in Clear Creek and Aspen. Details on these studies were reported in the March 1991 issue of *Colorado Medicine*. "It is important for us to continue to study the heavy metal levels in mining towns and to identify the specific factors which contribute to the variability in the lead levels," says Dr. Wilson.

Exposure studies are also underway at the ASARCO Globe Plant in Denver and the Rocky Mountain Arsenal. The Globe plant is the only working cadmium refinery in the U. S. and is located in an urban community of low income minority citizens. The exposure study at the Arsenal is looking at residents and their exposure to organic chemicals. In addition, major health studies of residents and workers at the Rocky Flats Plant are being conducted this year.

Dr. Hoffman concludes, "The programs in occupational and environmental epidemiology will expand our knowledge of the relationship between toxic chemicals and the health of Coloradans both at home and at work. Prevention and control programs can be developed based on our work with these environmental and occupational illnesses."

## Healthy People 2000 Summary Objectives

To improve environmental health, by the year 2000 . . .

- Reduce asthma morbidity
- Establish state plans to define and track sentinel environmental diseases including heavy metal and pesticide poisoning, acute chemical poisoning and environmental respiratory diseases
- Eliminate significant health risks from Superfund hazardous waste sites
- Eliminate blood lead levels above 25 µg/dl in children under age 5
- Perform lead based paint testing in at least 50% of pre-1950 homes
- Reduce outbreaks of water borne disease from infectious agents and chemical poisoning
- Reduce human exposure to criteria air pollutants
- Reduce potential risks to human health from drinking water and surface water
- Reduce human exposure to toxic agents by limiting industrial releases of toxins into the air, water and soil
- Reduce exposure to solid and hazardous waste by source reduction, recycling programs and household hazardous waste collection
- Increase the number of homes tested for radon and found to be safe or made safe

To improve occupational safety and health, by the year 2000 . . .

- Reduce work related injuries and deaths, skin diseases and hepatitis B infections
- Implement state plans for the identification, management and prevention of work related diseases and injuries
- Establish exposure standards to prevent the major work related lung diseases
- Increase the proportion of primary care providers who elicit occupational health histories
- Reduce the noise level and lead exposure for workers
- Increase the proportion of work sites with health and safety programs, including vehicle seat belt requirements and back injury prevention
- Establish small business consultation and assistance programs for health and safety



# Death Certificates— Fill Them Out Carefully (And Correctly)

by Ellen Stein, Director  
Division of Health Care Policy  
Colorado Medical Society

## Querying the Physician for Cause-of-Death

One of the responsibilities of the Nosology Unit of the Colorado Department of Health is the monitoring and improvement of cause of death data gathered via the Colorado Death Certificate. Cause of death certification constitutes a medical-legal opinion, not necessarily an absolute fact, since it is not always possible for the certifier to make a precise determination of interacting diseases or conditions. However, the operating premise of any effective death query program is that the person in the best position to make a judgment as to the chain of events leading to death is the certifying physician or coroner. Thus, on an ongoing basis the Nosology Unit queries physicians and coroners in order to (1) obtain the additional information necessary to properly classify the cause of death and (2) educate certifiers in the correct method of completing future death certifications.

Most query letters are sent to certifiers because of nonspecific,

The following are the most common errors/omissions made by certifiers:

- ① The use of vague, indefinite or ill-defined terms and symptoms (e.g. "shock," "coma," "senility") without stating their specific underlying cause;
- ② The use of "end stage" conditions (e.g. "cardiac arrest," "congestive heart failure," "renal failure," "hepatic failure") without stating their specific underlying cause;
- ③ The use of illogical, impossible or highly improbable causal sequences in Part I (e.g. line (a) "Diabetes" *due to* line (b) "Arteriosclerotic Heart Disease");
- ④ The use of inconsistent durations within the causal sequence (e. g. line (a) "Pulmonary embolism" - 4 days *due to* line (b) "Myocardial infarction" - 2 days);
- ⑤ Lack of specificity regarding conditions such as:
  - (a) Neoplasms/Tumors—Malignant? Benign?
  - (b) Malignant neoplasms—Primary site? Secondary sites? Histological/Morphological types?
  - (c) Cirrhosis of the liver—Alcoholic? Biliary?
  - (d) Heart Disease—Atherosclerotic? Hypertensive?
  - (e) Fracture—Traumatic? Spontaneous?
  - (f) Subdural hematoma—Traumatic? Spontaneous?
- ⑥ Failure to state what condition(s) necessitated the reported surgery or therapy;
- ⑦ Failure to provide the specific information requested in item 33a-f relating to the circumstances surrounding the reported traumatic injuries and external causes.

inaccurate or incomplete entries in the cause of death section of the certificate.

In 1989 (the most recent year for which query data are finalized) 8.55% of the 21,056 filed death certificates required queries to be sent to the certifiers.

86 percent of all queries were answered and returned: The average return time (measured from date of mailout to date of return was 12.66 days)

63 percent of all query responses yielded additional information that resulted in more accurate and specific

underlying causes of death than were originally reported.

From these and other figures it is evident that the Nosology Unit's death query program is an effective "after the fact" method of "cleaning up" cause of death data. However, it is equally evident most of the certifiers who are queried do have more specific information at their disposal at the time of the initial certification, but they fail to enter that information on the certificate. (Note: This discussion excludes those situations in which certifiers **cannot** report specifics because they are awaiting completion of toxicology/autopsy reports or the completion of police investigations.) Thus death certifiers (physicians and coroners) can make

significant contributions to the overall efficiency of death reporting in Colorado and to the improvement of cause of death data accuracy, quality and usefulness by **initially** reporting on the certificate the **most specific** cause of death information available to them.

The Data Management Section invites all physicians and coroners to contact its Nosology Unit when questions arise concerning cause of death certification. Questions should be directed to Greg Wolfe (Unit Supervisor) at (303) 331-4907 or Brenda Davis (Nosologist) at (303) 331-4884.



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Home Phone Number

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## Colorado Gynecological and Obstetrical Society



### Recognition Award goes to Tommy Thompson

Dr. Horace "Tommy" Thompson received the Second Annual Recognition award from the Society at the September membership meeting. The dinner meeting was attended by members of his immediate family, adding a special feeling to the acknowledgments shared during the evening. Dr. Thompson attended the University of Colorado School of Medicine, was a professor at the University of Colorado School of Medicine, and was Director of Obstetrical and Gynecological Services at Denver General Hospital for 12 years. He was recognized for his outstanding contributions in medical research and education, as a pioneer in ultrasound, and his lifelong commitment to women's health care.

### Teen Pregnancy Initiative accepted as public service project by Denver Advertising Federation

The Teen Health Education Committee's Initiative on Teenage Pregnancy has been accepted by the Denver Advertising Federation as their public service project for 1992. The DAF is one of the oldest and largest advertising federations in the U.S. The Committee has initiated a public awareness campaign concerning teenage pregnancy that will be launched early in 1992, initially targeting Denver Public Schools. The Colorado ObGyn

Society will be the only state chapter of ACOG taking such a leadership role in regard to teenage pregnancy. Dr. Jack Thorne, Chairman of the Committee, can be reached at (303) 234-0800 if you wish to volunteer or have questions.

### New President Dr. Jaime McGregor

Dr. Jaime McGregor has taken over as President of the Society for 1992. Dr. McGregor is the Vice Chairman of Academic Affairs, Department of Obstetrics and Gynecology, University of Colorado health Sciences Center, and is an Adjunct Associate Professor, Dept. of Food Science and Human Nutrition, Colorado State University. Dr. McGregor has received numerous academic honors, and has participated on several community-based committees. He has been a very successful Program Chairperson for the Colorado ObGyn Society since 1986.

### January Membership meeting at Marriott

January 6, 1992, Dr. Allen DeCherney, Professor at Yale University will give a presentation entitled "Revolution In Infertility Surgery." A mini-course on Hysteroscopy will also be given, beginning at 4:00 p.m. Location: Marriott at I-25 and Hampden; cocktails at 5:45 p.m. with dinner at 6:45 p.m.

### February Membership meeting at Marriott

February 3, 1992, Dr. William Creasman, Professor, Medical University of South Carolina, will give a presentation on the "Use of Hormones in Gynecological Cancer Patients." Location: Marriott at I-25 and Hampden; cocktails at 5:45 p.m. with dinner at 6:45 p.m.

### Legislative Breakfast

The 3rd Annual Legislative Breakfast will be held on Valentine's Day, February 14, 1992, at 7:30 a.m. in the Capitol Building Rotunda. This is an opportunity to meet your legislators in an informal way.

### March meeting on domestic and sexual abuse, and AIDS

A special President's Symposia will be held in March (tentatively scheduled for March 13) which will cover the topics of domestic and sexual abuse, as well as AIDS. Health care professionals will be invited, as well as members of the community. For information, please call Betsy Fox at (303) 355-8845.

For information about monthly membership meetings call 693-6127.

For information about other society activities, call 355-8845.



## Assistance for AIDS Specific Drugs (AASD) Program

In September of 1991, \$200,500 was made available to provide HIV specific drugs to Colorado residents who are HIV positive and whose incomes are such that they qualify for the Colorado Resident discount Program (CRDP). Drugs available through this program include AZT, ddI, acyclovir, gancyclovir, inhaled pentamidine and several other HIV-specific drugs. This program takes the place of the previous program that was administered through the Department of Social Services. Funding for this program has been rolled into the Ryan White Title Two federal funding through the Governor's AIDS Task Force.

Residents of Denver County can obtain their drugs at Denver General Hospital with a current hospital card and a valid prescription. Residents outside of Denver County can obtain their drugs one of two ways from University Hospital (UH). If the patient is generally seen at University Hospital or lives less than 40 miles from the hospital, they may pick up their medications at the UH pharmacy. If patients live further away, or have difficulty traveling, they may choose to mail their prescriptions and proof of current CRDP rating to the UH Pharmacy, "attention AASD Program," Campus Box A027, 4200 E 9th Ave, Denver CO 80262. The prescription must state, "Draw from AASD Supply."

Health care providers and patients may call, toll free, 1-800-858-AIDS for more information regarding the AASD program.

## Cytology Update

The increasing health threat posed by breast and cervical cancer, coupled with new federal regulations on laboratory result reporting, has motivated the Colorado Department of Health (CDH) to sponsor a training seminar in Gynecological Cytology February 8.

Judy Donaldson, Lab Training Coordinator for CDH's Division of Laboratories, says the seminar will address practical use of the Bethesda System, a very recent technical change in the reporting of cytology results mandated by the Clinical Improvement Act of 1988. The new system stresses a more narrative approach to reporting, as opposed to the code based system currently in use.

In addition, quality assurance standards will be reviewed by Patrick James, MD. Shirley Greening, a cytologist and attorney, will deal with how the regulations will impact practices of cytology and pathology labs.

This seminar is part of a project which also subsidized breast and cervical cancer screening to over 12,000 Colorado women in its first year, according to Dr. Carole Chrvala, Cancer Control Director for CDH.

For more information, call Judy Donaldson at (303) 331-4712 or Dr. Carole Chrvala at (303) 331-8407.

## Law passed for statutory protection of retirement funds

In the article by Ms. Constance Wood, Esq., on "Starting A Practice: Preventive Law," (November, 1991 *Colorado Medicine*), Ms. Wood stated that Simplified Employee Pension Plans (SEP) were not protected from creditors. Since the submission of the article, Colorado has enacted a statutory provision protecting all retirement plans including IRAs and SEPs from creditors'

## Texas Medical Association sends CME ALERT!

The Texas Medical Association recently discovered a promotional brochure which contains that Association's continuing medical education accreditation statement designating Category 1 credit of the Physician's Recognition Award of the AMA for specialty board review courses. The Texas Medical Association had explicitly refused to grant credit for these courses prior to distribution of this brochure by the Osler Institute of Terre Haute, Indiana.

Since this material was distributed through a nationwide mailing, Colorado physicians may have received such offers and solicitation:

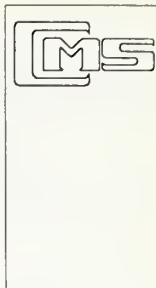
Officials of the Texas Medical Association (TMA) have stated to *Colorado Medicine* that TMA is in no way associated with any 1992 board review courses conducted by the Osler Institute of Terre Haute, Indiana.

Physicians with questions or concerns about CME credit for 1992 board review courses which carry the TMA's CME accreditation statement should contact: Carrie Laymon, TMA Medical Education Department, 401 West 15th Street, Austin, TX 78701-1680. Telephone (512) 370-1446.

claims. The statute (CRS 13-54-102; Exemption from attachment of IRA and Pension Plans) has not yet been tested in court.

In noting the change, Ms. Wood told *C/M* that "Colorado law has a very good chance of being upheld, although some states' attempts at protecting retirement funds have not been successful."





## HCFA offers 30-day grace period for use of Evaluation/Management CPT codes

HCFA has announced a 30-day grace period to allow time for physicians to become acquainted with the new visit codes. For services provided from Jan. 1 - Jan. 31, HCFA will accept and pay claims submitted using the 1991 visit codes at the 1991 payment level. The AMA had argued strongly that physicians needed more time to familiarize themselves with the new codes, and that HCFA needed to provide a grace period that was national in scope. HCFA, however, underscored that the new visit codes are effective on January 1. On and after February 1, carriers will deny all assigned claims that use the old codes. For unassigned claims, the contractors will contact physicians to obtain the correct codes. This process is consistent with other HCFA policies to protect beneficiary out-of-pocket costs.

## Dottie Lamm to address Women In Medicine Section at February meeting

The Women In Medicine Section's Interim Business Meeting February 27, 1992, will feature Dottie Lamm as dinner speaker. She will address the group on *"More Kids, More Chaos?" Population Policy in the Third World.*

The dinner meeting will be at 5:30 p.m. at the Wellshire Inn. Tickets are \$16.00. For reservations or further information, contact the Women In Medicine Section at Colorado Medical Society, 779-5455 or 800-654-5653.

## CMS/AMA Alternate Delegate Rob Bogin, MD, is on organized medicine "fast track"

Robert M. Bogin, MD, Immediate Past Chairman of the AMA-YPS and newly-elected CMS Alternate Delegate to the AMA, has been busy at the national level in numerous areas:

In July, Bogin volunteered for the AMPAC Campaign Management School, afterward saying "I survived Campaign Management School! I had heard a lot about it. In fact, I had been warned about it....." After completing the school and reflecting on it, Bogin added "I have become involved in a local political campaign; after describing the campaign school to the candidate and his staff, I was given instant credibility because of the reputation of the organizers. Although the AMPAC Campaign School is not for the faint of heart, I give it my highest recommendation for anyone with a strong interest in becoming involved in a political campaign."

In August, Dr. Bogin received recognition in the current issue of *"Sports Medicine"* for his role in counseling Mackenzie Phillips, a defensive tackle for the University of Arkansas' Razorbacks.

In October, Bogin was an attendee of AMA's 1991 National Political Education Conference, participated in lobbying legislators on Capitol Hill, participated in legislative and campaign grass roots "how to" sessions, heard presentations by the national political party chairmen, and received updates on the 1992 presidential and congressional elections.

Dr. Bogin has been an active representative of the CMS Young Physicians Section and has helped carry their concerns to the national level where he has participated in AMA-YPS efforts to create AMA policy on a wide range of issues, including:

- Anabolic Steroids
- Child Safety Restraint Use in Aircraft
- Tobacco Advertising in Minority Neighborhoods
- MAAC Discrimination Against Young Physicians\Bicycle Helmets
- Adequate Funding of the WIC program
- Medicare Reimbursement for Young Physicians OBRA 1990
- Delivery of Health Care by Non-Physicians
- Caller Identification Telephone Services
- Physicians with Communicable Diseases

Colorado Medical Society wishes Dr. Bogin good health and a continued enthusiasm for his excellent works in organized medicine.

## AMA's James S. Todd, M.D. to speak to the CMS Interim Meeting

Dr. James S. Todd, Executive Vice President of the American Medical Association will keynote the 1992 CMS Interim Meeting.

Dr. Todd has formally accepted the invitation by CMS President Harrison G. Butler, III, MD, to address the meeting, which will be held March 7 - 8, 1992.

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	<b>February 19</b>	<b>CMS/Copic Offices, 7800 East Dorado Place, Greenwood Plaza</b>
	<b>March 18</b>	<b>CMS/Copic Offices, 7800 East Dorado Place, Greenwood Plaza</b>
	<b>April 21</b>	<b>CMS/Copic Offices, 7800 East Dorado Place, Greenwood Plaza</b>
	<b>May 20</b>	<b>CMS/Copic Offices, 7800 East Dorado Place, Greenwood Plaza</b>
	<b>June 17</b>	<b>CMS/Copic Offices, 7800 East Dorado Place, Greenwood Plaza</b>

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Kathy Gardner, BSN, MA/Richard H. Thompson, Jr., MD/Margaret Cary, MD, (BME) for Copic.

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## 1992 Interim Meeting—March 6-8 "Health Care Policy for the 90's" The Cure Is In Working Together



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### In this issue:

- Making a difference in state and national health care policies: Colorado physicians can!  
*CMS President Harrison G. Butler, III, M.D.*
- Governor prescribes "crisis intervention" in Colorado health care  
*Colorado Governor Roy Romer*
- National health care priorities have Colorado physician impact  
*United States President George Bush*
- So...What's new? History repeats itself  
*Frederick A. Lewis, Jr., MD, Past-President, Colorado and Denver Medical Society*

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## New Health Chief to Speak at Interim Meeting

Patricia A. Nolan, MD, MPH, Governor Romer's recent choice to head the Colorado Department of Health, will address a luncheon at the Interim Meeting of the Colorado Medical Society.

Dr. Nolan was selected in December after a year-long nationwide search for a successor to Dr. Thomas M. Vernon, who resigned in late 1990. Her career has ranged from being a public health worker in the boroughs of New York City to being the director of an innovative Arizona medical cost containment program.

"I selected Patricia Nolan for this vital Colorado position because of her broad experience in both public and environmental health," said Governor Romer. "It is key that the Department have a director with the training and experience necessary for the department to focus on and excel in both of these areas."

Prior to coming to Colorado (her appointment becomes effective in February if confirmed by the state Senate) Dr. Nolan was medical director of the Phoenix based Arizona Health Care Cost Containment System. That program was credited for containing Arizona's Medicaid costs. Prior to that, she served as director of the Pima County Health Department in Tucson. Her key areas of concern included improving the quality of the air and the handling of hazardous waste.

Dr. Nolan received her medical degree from McGill University in Montreal, where she also served on the medical faculty. She also holds a Master's degree in Public Health from Columbia University. She has worked as a district health officer and as a regional health director in New York City boroughs and as a public health physician for the New York City Health Department. She served as associate director of several sections of the Illinois Public Health Department. She is married and has two daughters.

Dr. Nolan made the news in Colorado even before her arrival when a group of environmentalists accused her of ignoring their concerns over trichloroethylene (TCE) contamination of Tucson's groundwater supply while she headed the Pima County Health Department. Dr. Nolan told local reporters there was no significant short term danger and she and her staff sealed off the contaminated wells and treated the pollution as soon as TCE was identified. She said pollution prevention will be a key focus in Colorado, along with cleanup, while such activities as figuring out who was to blame and assigning reparations properly belong in the court system.

Dr. Nolan will speak to a noon luncheon on Saturday, March 7, 1992 at the Sheraton Denver Tech Center Hotel. Look in this issue for information and a registration form.



## Med Fax: Medical Legal News

by Karen B. Best, Esq., an Associate  
with the law firm of Montgomery Little  
Young Campbell & McGrew, PC,  
attorneys to the CMS.

*This column is not legal advice, but is for general  
information only. For help with specific problems,  
readers should consult an attorney.*

### Experimental Treatment?

Is high dose chemotherapy with autologous bone marrow transplantation (ABMT) for treatment of breast cancer experimental or investigational? In a lawsuit filed against K-Mart Corporation, Susan Clark asked for an order forcing the company's health plan (administered by Blue Cross/Blue Shield of Michigan) to cover the cost of the treatment, which was estimated to be in excess of \$150,000 for the hospitalization alone. The plan took the position that the treatment was excluded from coverage as experimental and investigational.

This patient won, as have so many others fighting over the same question. The Court found that ABMT is no longer an experimental treatment for breast cancer and that the plan administrator's decision to deny the claim was "arbitrary and capricious." In an unusual move, the court took "judicial notice" that the hospital would have to pay back K-Mart if it was later found that K-Mart was not liable for the costs of the procedure. This way the patient could receive the treatment now and the lawyers and companies could fight about who would pay for it later. *Clark v K-Mart Corporation*, Case No 91-1431, US District Court for the Western District of Pennsylvania.

### Tort Reform Damage Cap

Alabama enacted a statutory cap of \$400,000 on noneconomic damages. Noneconomic damages compensate for pain and suffering, loss of enjoyment of life and other injuries which, unlike medical bills, cannot be readily calculated.

Barbara Moore sued Mobile Infirmary Association for negligently administering a sedative and was awarded \$600,000, an amount which includes the statutory cap on noneconomic damages. Moore appealed. In another blow to tort reform legislation, the state Supreme Court found that the cap violated the claimant's state constitutional right to a jury trial and the right to equal protection. The court reasoned that the correlation "between the damages cap and the reduction of health care costs

is, at best, indirect and remote," while the burden imposed upon the most severely injured is direct and concrete. "Unlike the less severely injured, who receive full and just compensation, the catastrophically injured victim of medical malpractice is denied any expectation of compensation beyond the statutory limit." *Moore v Mobile Infirmary Association*, Case No 89-1087, Alabama Supreme Court.

### Who Are Your Patients?

Let's say a radiologist sees abnormalities on a chest X-Ray taken during a pre-employment physical examination. And let's say the radiologist doesn't tell the person about the abnormalities. The person has a progressive lung disease, sarcoidosis, which goes untreated, causing the person to become permanently disabled.

Does the radiologist, or any examining physician for that matter, have a duty under *Washington* law to inform those examined of abnormal test results, absent a doctor-patient relationship? Yes, for the simple reason that injury to the person is foreseeable when and if the doctor fails to tell the person about abnormal findings. *Daly v United States*, Case No 90-35880, Ninth Circuit. Duty is the prerequisite to liability. Without duty, there can be no breach (malpractice). However, duty can arise whenever the outcome is foreseeable, and not only when the physician and person agree to a treatment relationship.

A similar case was decided recently in Colorado. The claimant in a personal injury case was referred to a physician for an independent medical examination (IME). The physician was not retained to provide any medical care or treatment to the claimant, and the claimant did not pay the physician for any services that he rendered. The claimant, who brought suit claiming shoulder and neck injuries in an accident, advised the IME physician that she had undergone three prior back surgeries and that she was then in therapy. The IME physician referred her to another facility for a "functional capacity examination." She injured her back during the examination at the other facility and sued the IME physician.

The trial court dismissed the claims, finding that the IME physician owed no duty to the claimant with respect to the test administered and therefore could not be liable for any injury suffered as a result of that examination.

Wrong. The Colorado Court of Appeals reversed, holding that although "the nature of the duty owed depends upon the nature of the professional responsi

*Continued on following page...*



*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

**Prosper Meniere Society**

Winter Meeting (Alternative Surgeries for Vertigo)

February 20-23, 1992

Aspen, CO

Jane Wells (303) 788-4230

**University of Arizona**

Practical Radiology

February 24-27, 1992

Tucson, AZ

(602) 626-7832

**Prosper Meniere Society**

Electrocochleography/Otoacoustic Emissions Workshops

February 26-March 1, 1992

Denver, CO

Jane Wells (303) 788-4230

**University of Arizona**

Geriatric Medicine Update & BC Review

February 27-29, 1992

Tucson, AZ

(602) 626-7832

**University of Colorado at Colorado Springs**

Issues in Child Abuse Teleconference

Registration Deadline February 25, 1992

Various locations

UCCS (719) 593-9191

**World Congress on Healthcare**

World Emergency Conference (live broadcast)

from New York by satellite

February 27, 1991

Mike Dulligan (800) 879-3857

**Medical Records Institute**

Patient Cards & Computerization of Medical Records

New Orleans, LA

March 4-7, 1992

Ruth Dearden (617) 964-3923

**University of Arizona**

Practical Management of Rheumatic Disease

Tucson, AZ

March 5-7, 1992

(602) 626-7832

**LDS Hospital/University of Utah**

Ethics Committees and Morality Plays: A Shared

Search for Virtue

Salt Lake City, UT

March 13, 1992

(801) 321-1135

**University of Arizona**

Epilepsy & Behavior

March 14, 1992

Tucson, AZ

(602) 626-7832

**Univ. of Calif. Med School Dept. of Radiology**

Radiology In Asia

Singapore, Bali, Bangkok, Hong Kong (option to

Beijing and Kwellin)

March 14-27, 1992

Dawne Ryals (404) 641-9773

**Colorado Safety Association**

Rocky Mountain Health & Safety Conference

Colorado Convention Center, Denver

March 25-27, 1991

Melodye Turek (303) 373-1937

## Medico-Legal News from Preceding Page...

bility assumed, we conclude that, under the undisputed facts here, the defendant owed to plaintiff the duty not to require her to engage in physical tests, whether administered by him or by some third party, which a reasonably careful physician, under the same or similar circumstances, would not have required her to perform." *Perkins v Greenberg*, Case No 90CA1765. In other words, the fact that there is no diagnostic or treatment based physician-patient relationship, will not insulate absolutely the physician performing an IME from potential liability.

# CMS Med Fax

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## **American Lung Association of Montana**

**Big Sky Pulmonary/Ski Conference**

**Helena MT**

**March 25-29, 1992**

**(406) 442-6556**

## **Office for Substance Abuse Prevention**

**Peer Assistance: A Model for the Helping Professions**

**Hyatt Regency Denver**

**March 28-31, 1992**

**800-765-0263**

## **World Congress on Healthcare**

**World Congress on Healthcare (live broadcast)  
from New York by satellite**

**April 8-9, 1991**

**Mike Dulligan (800) 879-3857**

## **Harvard Medical School**

**Mothers: Victimization, Stigma and Survival**

**Children's Hospital, Boston, MA**

**April 22-24, 1992**

**(617) 432-1525**

## **American Academy of Neurology**

**Annual Meeting**

**San Diego CA**

**May 3-9, 1992**

**(612) 623-8115**

## **World Congress on Healthcare**

**ASH Annual Meeting (live broadcast)  
from New York by satellite**

**May 7-11, 1991**

**Mike Dulligan (800) 879-3857**

## **Presbyterian/St. Luke's Healthcare System**

**Born Too Soon: The Fetus as a Patient**

**Red Lion Hotel, Denver**

**May 9, 1992**

**Mary T. Fletcher (303) 869-1900 or 800-633-6824**

## **World Congress on Healthcare**

**World Telecommunications Conference (live broadcast)  
from New York by satellite**

**May 20, 21, 1991**

**Mike Dulligan (800) 879-3857**

## **American Academy of Pediatrics**

**Perinatal Pediatrics Conference**

**Kaual, Hawaii**

**May 21-24, 1992**

**L. Joseph Butterfield, MD (303) 861-6509**

## **American Medical Association**

**Financial Strategies for Retirement**

**Denver, Colorado**

**June 5, 1992**

**(312) 419-5042**

## **Rush-Presbyterian-St. Luke's Medical Center**

**Cytokines and Transplantation**

**Chicago, IL**

**May 30, 1992**

**Suzanne Buss (312) 942-6242**

## **American Medical Association**

**Successful Money Management**

**Denver, Colorado**

**June 6, 1992**

**(312) 419-5042**

## **Univ. of Calif. Med School Dept. of Radiology**

**Radiology in Africa**

**Nairobi, Samburu, Kenya, Masai Mara**

**October 10-24, 1992**

**Dawne Ryals (404) 641-9773**

## **Prosper Meniere Society**

**Diagnostic & Rehabilitative Aspects of Balance &  
Movement Disorders**

**December 2-6, 1992**

**Denver, CO**

**Jane Wells (303) 788-4230**

## **Prosper Meniere Society**

**Symposium & Workshops on Surgery of the Inner Ear**

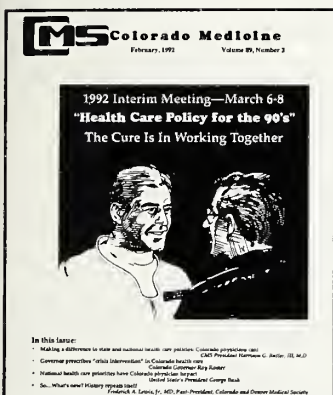
**July 20-25, 1991**

**Snowmass, CO**

**Jane Wells (303) 788-4230**

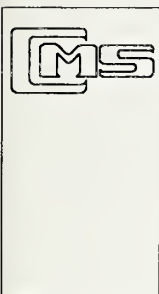






## Cover Story

The physician should be prominently in the picture whenever health care policy decisions are made, but the physician cannot shoulder the burden alone. The cure is in working together. See the following pages for more...

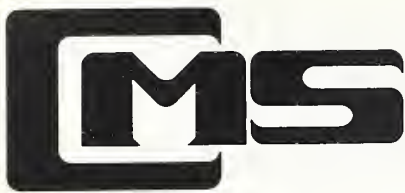


## Departments

- 33 President's Letter
- 51 The Lobby
- 53 Committee Update
- 57 Letters
- 59 In Memory
- 62 Health Department
- 63 Copic Comment
- 64 Classified Advertising

## In This Issue...

- 33 Colorado physicians must—and are—influencing health care policies in our state and nation.  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 34 Governor Romer details his plan to meet "health care crisis"  
*Roy Romer*  
*Governor, Colorado*
- 36 Health care priorities addressed on a national scale—items which will affect Colorado physicians  
*George Bush*  
*President, United States of America*
- 37 As always, answers to health care problems must transcend blaming physicians and hospitals  
*Frederick A. Lewis, Jr., MD*  
*Past President, Colorado and Denver Medical Society*
- 39 Déjà Vu—History repeats itself in current controversies over health care priorities  
*William S. Pierson*  
*Managing Editor, Colorado Medicine*
- 43 Health Care Policy for the 90's—Interim meeting to address critical issues
- 55 Problems in providing rural health care addressed by CMS—making progress
- 58 9Health Fair—Making patients aware of their need for your medical care services



# Colorado Medical Society

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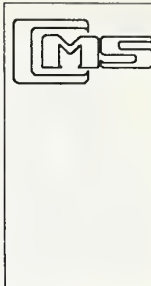
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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor





*Harrison G. Butler, III, MD  
President, Colorado Medical Society  
1991-1992*

1992 is unquestionably the year to discuss health and medical care in the United States. This topic has been getting an increasing amount of attention for the last several years, but the Pennsylvania Senate race has definitely put health care on the front burner. The Democrats see this as an issue they can exploit in the next national election. The Democratic Presidential candidates are using this as the "anvil" issue. They are attempting to connect other issues that are not normally related to the so-called "high cost" of medical care. Bill Clinton of Arkansas was quoted as saying in Detroit that the way to compete with Japanese automobile manufacturers was to control the cost of health care, thus making U.S. auto makers more competitive. As you can see, a trend may be developing that all of the problems of the American people can be attributed to the cost of health care.

Now, Bill; that is just plain silly! Fortunately, not all politicians are as poorly informed as indicated by this blatant "election year statement."

Sandy Maloney, Rod Brewster, Sue Ellen Quam and I met with Governor Roy Romer in what I consider a very productive exchange of ideas. Governor Romer asked the Colorado Medical Society for help in determining both a short- and a long-term strategy for a health care policy for Colorado. The State of Colorado has a \$100 million shortfall in the Medicaid budget and changes are desperately needed. We will be asking for your help

## *Now, Bill; that is just plain silly!*

as we proceed. This policy could also have national ramifications as Governor Romer will assume the Chair of the National Governor's Association in June. It is vitally important that we don't drop the ball on this opportunity. The entire state was watching and listening as the Governor mentioned Colorado Medical Society in his state of the state address (see excerpts from the address in this issue).

Our meetings on health policy have not been limited to the Governor's office. An erudite delegation including **Drs. John Sbarbaro, John Farrington, Bill Markel, Rob Bogin, Sandi Maloney** and I met with Representative David Skaggs (Congressional District #2) on January 9th. We served primarily in an educative role. Rep. Skaggs was attentive and asked insightful questions. (This was also the last meeting in which Mitch Stahl participated. She will be fondly missed in the processes.) The exchange was frank and, I believe, informative. What influence we had is yet to be determined.

Later that same day, Sandi and I participated in Senator Tim Wirth's

town meeting on health care reform held in Pueblo. About two-hundred interested citizens attended and the discussion seemed to be based around special interest groups who were angry and frustrated with the present system. I have been included on a state health council organized by Senator Wirth. The council is to gather information and draft a policy statement on health care by

March, 1992. Wirth's opinion is that there will be federal legislation on health introduced at that time.

I didn't come away from that meeting with any new information. It is obvious to me that the people who are motivated to attend meetings such as in Pueblo want the very best medical care; they want it immediately or on demand, and it must be free or at extremely low cost.

I was happy that **Drs. Jim Meeuwse**n and **Roger Miller** attended and added some facts to the discussion. Before they spoke up, the Canadian system of health care seemed to be the preferred system to those in attendance. It also took considerable courage on the part of Meeuwse and Miller, since this was not a doctor-friendly group.

There will be many more meetings on the topic of health care...I can hardly wait! I'm not very optimistic as to the final product. There are a lot of demands, very little money and an enormous amount of politics involved in the process.

Please call or write with your opinions on this very complicated subject.

# Governor Romer Sees 'Health Care Crisis'

## Asks CMS for help in meeting rural health care needs

*Colorado Governor Roy Romer reported on the "state of the State" in a speech to a joint session of the Colorado Legislature January 9, 1992. In that speech, the Governor focused largely on education and economic development as his priorities for the coming year. In addition, he talked about the health care situation in Colorado and proposed some remedies. We reprint here that portion of the speech. Ed.*



Health Care: It is a national problem, but we can't wait for a national solution. Our system is in crisis. We see this crisis in the growing number of

Coloradans with no health insurance. We see it in exploding Medicaid costs which are severely crippling the State of Colorado. We see it in the trouble businesses have in providing insurance to their employees and still staying competitive.

Excessive health costs are a serious threat to this country. Thirteen cents of every dollar we earn goes to health care. By the end of the decade, it could be 17 cents. We can't tolerate that and make the other personal and public investments we've talked about.

Therefore, we must make a commitment to fundamental health care reform in Colorado. Such reform must have six components — universal coverage, cost containment, prenatal and child health, Medicaid reform, insurance reform and rural health care. Let me outline each briefly.

### 1. Universal Coverage.

It is simply unacceptable that, in 1992, nearly half a million Coloradans have no health insurance. It's a major failure of our system. Anyone who needs a doctor should be able to see one, regardless of ability to pay.

We must commit now to finding a way to ensure that all Coloradans can get the basic, medically necessary, cost-effective health care they need. It's necessary. It's a human right. And it's achievable.

Therefore, I want you to join me in directing the Health Policy Council, created at the suggestion of this General Assembly in 1990, to study the alternatives for assuring universal coverage and report back to us by May.

I suggest the Council evaluate each alternative based on the following criteria: How well does it contain costs; How well does it provide basic coverage; How equitable is its financing mechanism; What incentives does it provide for healthy life-styles; How well does it address the professional shortage crisis in rural Colorado; and

more. After the alternatives are evaluated, we must go to the people of the state and ask for their input. By the 1993 session perhaps we will have reached a consensus for a Colorado solution to the problem of access.

### 2. Cost Containment

The Small Business Advisory Committee on Health Insurance has recommended that I establish a cost containment commission as a first step toward health care reform. I would like you to join me in establishing this commission. I understand that Senator Schroeder and Representative Schauer have a bill to do that, and I hope we can work together.

Let's set a goal to cut medical

*I intend to ask the  
Colorado Medical  
Society ... to advise*

inflation in half by 1994 and to bring it in line with the general inflation rate by 1996.

In addition, there are some steps we can and should take right now to cut costs.



In 1987, we suspended the Hospital Certificate of Need program. I think that was a mistake. We've seen an explosion of costly and duplicative services since then. Let's reestablish the Certificate of Need. Forty States have such programs. Let's learn from them and see what we can do to make it work here.

Next, let's mandate a uniform health insurance billing form this session. It's a common-sense step we can take right now.

Next, let's draft a bill that prohibits health care practitioners from referring patients to services in which these health care workers or their families have a financial interest.

And let's direct the Chiropractic Board to study over utilization and abuse of chiropractic services.

I know I'm treading on vested interests here. That's deliberate. Fundamental reform means we need to open all the doors and see what's inside.

### 3. Prenatal and Child Health

Each year we have about 3,000 Colorado women who do not receive the prenatal care they need. They are falling through the cracks because they are not eligible for Medicaid and they do not have private insurance for prenatal care and delivery.

As a result, the chances of these women delivering low birth weight babies are high. The chances that these babies will have long term disabilities are high. The chances that these babies will need special education and long term care of some type are high. We should work to prevent that.

Similarly, many major, dangerous childhood illnesses, like measles, are preventable. Yet, just this past year in Colorado, four of every 10 Colorado two year olds were not immunized against preventable diseases.

Having healthy children is the first and most essential precondition to schooling. Let's make a commitment to our children by providing prenatal care and immunizations.

In reviewing the options for health care reform, I want the Health Policy Council to give the highest priority to how we can best provide these services for pregnant women and infants. I want them to advise us this session so that we can act now.

### 4. Medicaid Reform

In my September address to this assembly, I laid out seven strategies to further contain Medicaid costs. Since September, thanks to this legislature and the state Social Services Board,

these seven strategies have largely been implemented.

In September, I also directed the Department of Social Services to report on additional Medicaid cost containment steps we could take. That report has formed the basis for productive discussions between the Department of Social Services, members of the HEWI [Health, Education, Welfare and Institutions] Committee and the JBC [Joint Budget Committee]. There should be more proposals coming to you this session, involving managed care, co-pay, service limits review and competitive bidding. I encourage you to give serious consideration to these.

As you know, I have appointed Dr. Patricia Nolan to head the Colorado Department of Health. Dr. Nolan has been medical director of the Arizona Health Care Cost Containment System, the agency that administers Medicaid in Arizona. I know that she will bring expertise to us which we will be able to

use in this area.

### 5. Insurance Reform

I have asked Joanne Hill, the Commissioner of Insurance, to work with you to implement the recommendations of the Small Business Advisory Committee on Health Insurance to help ensure that small businesses can get affordable health care coverage.

I also have asked the Commissioner to report to me on further steps we can take to level the playing field in terms of access to and cost of health insurance. Specifically, I'm interested in requiring all insurers to use a modified community rating system in order to spread costs more evenly and to have an open enrollment period at least once a year.

And we need to stem the growing problem of insurance fraud and abuse. I understand that the Insurance Commissioner is working with the Attorney General on this specific issue.

### 6. Rural Health

The shortage of primary care providers has reached crisis proportions in rural Colorado. More than half our counties are designated as Federal Health Care Professional Shortage Areas. A number of counties have no doctors at all. Many doctors in rural areas do not accept Medicaid patients. We cannot let this shortage cripple the economic development of these rural areas.

I intend to ask the Colorado Medical Society and the University of Colorado Health Sciences Center to jointly advise the Executive Branch and the Health, Education and Welfare Committees of both the House and Senate on what is the most cost effective plan for addressing this problem, including the possible use of scholarships for medical students that would be forgiven upon service in rural areas.

***“We must make a commitment to fundamental health care reform in Colorado”***

# President Bush Addresses Health Care Priorities

*On January 28, 1992, President George Bush delivered his State of the Union Address to a joint session of the U. S. Congress. In that speech, the President touched upon several priorities for health care which may personally and professionally affect each practicing Colorado physician. Here is the portion of the address which deals with health care.*

We must reform our health care system. For this too bears on whether or not we can compete in the world.

American health costs have been exploding. This year America will spend over \$800 billion on health. And that's expected to grow to \$1.6 trillion by the end of the decade. We simply cannot afford this.

The cost of health care shows up not only in your family budget, but in the price of everything we buy and everything we sell. When health coverage for a fellow on an assembly line costs thousands of dollars, the cost goes into the products he makes — and you pay the bill.

We must make a choice.

Now some pretend we can have it both ways. They call it "play or pay" but that expensive approach is unstable. It will mean higher taxes, fewer jobs and eventually, a system under complete government control.

Really, there are only two options: We can move toward a nationalized system — which will restrict patient

*Our private health care system gives us, for all its flaws, the best quality health care in the world.*

choice in picking a doctor and force the government to ration services arbitrarily. And what we'll get is patients in long lines, indifferent service and a huge new tax burden.

Or, we can reform our own private health care system — which still gives us, for all its flaws, the best quality health care in the world.

Well, let's build on our strengths.

My plan provides insurance security for all Americans — while preserving and increasing the idea of choice. We make basic health insurance affordable for all low income people not now covered. And we do it by providing a health insurance tax credit of up to \$3,750 for each low income

family. And the middle class gets new help too. And, by reforming the health insurance market, my plan assures that Americans will have access to basic health insurance even if they change jobs or develop serious health problems.

We must bring costs under control, preserve quality, preserve choice and reduce the people's nagging daily worry about health insurance. My plan, the details of which I will announce very shortly, does just that.

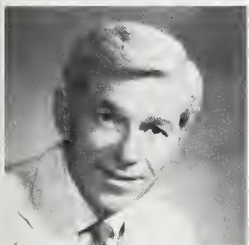
*Controversy over how these items were to be funded delayed publication of the President's proposed budget somewhat, as White House staffers worked to include these proposals accurately in the document. The President re-worked his speech as late as the afternoon before he delivered it. The President has challenged Congress to pass his package by March 20, 1992. He is expected to unveil a comprehensive health care reform plan on February 8, 1992.*



# **T**he More Things Change, the More They Stay the Same

**Evaluation, Conclusions Still the Same...  
Still Waiting to be Implemented**

*"An increasing amount of sound and fury."*



*Frederick A. Lewis, Jr., MD*

Bill Pierson asked me to comment on the article, *Ethics and Managed Health Care* (on the following pages) which brought back all kinds of nostalgic memories - not the least of which was that the DMS Ethics Committee of 15 years ago marked my first meeting with the same Bill Pierson.

My overall impression of the past 15 years in the cost containment arena is that each year has brought forth an increasing amount of sound and fury, none of which has had much impact on the rising cost of medical care.

Over this period of time, many very bright and gifted individuals (a few of them even physicians) have come up with a vast array of alternative solutions to the problem, none of which has worked.

In the early days, we thought of three broadly interrelated indices of health care - cost, quality and access. Cost was felt to be inversely correlated with quality and access. It would appear

## ***It's a Societal, not a Medical Problem***

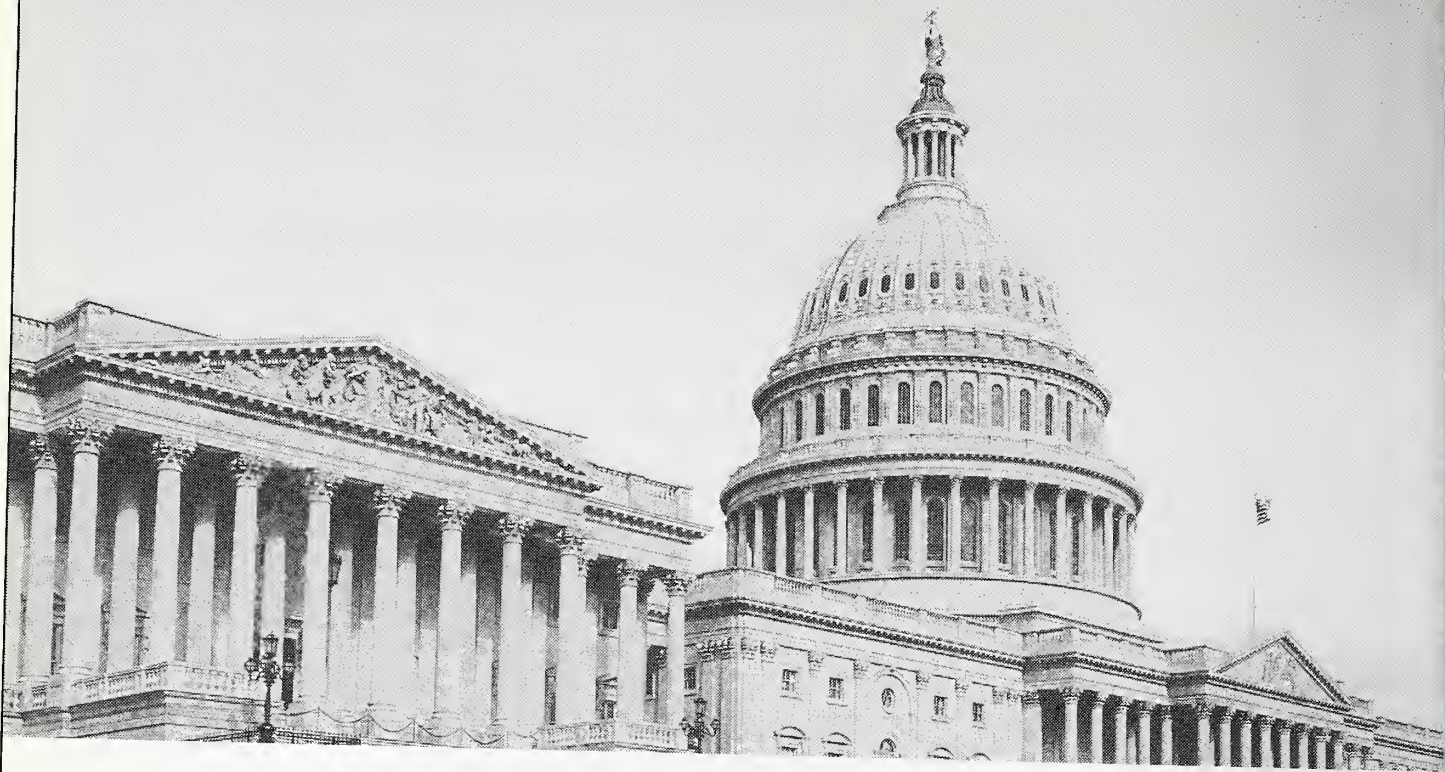
that this simple axiom continues to be true. All of the improvements in technology have undoubtedly contributed to an increase in quality and to a corresponding increase in cost. Managed care, HMOs, and PPOs are all efforts to reduce costs through limitation of access. Compromises in quality or access always raise potential ethical concerns.

The number of uninsureds has continued to rise and the retention of health insurance has begun to determine the future of people's lives. We need to be very clear that all of the efforts to contain costs have, thus far, been unsuccessful in the sense that health care costs have continued to rise faster than the overall rate of inflation.

Our conclusion, 15 years ago, was that the only logical solution was some kind of rationing of health care. In 1992, this would still appear to be the only solution. This puts it right back into the ethical arena, almost as if it never left. However, we

were also very clear in 1977 that the seemingly inescapable yearly escalation in health care costs was a societal, not a medical, problem. The solution is a legitimate societal concern which should not and can not be delegated to the medical profession. We should certainly participate in discussions aimed at clarifying problems and finding solutions but, at the same time, we must clearly recognize the limitations of our authority and responsibility in this process.

*NOTE: Dr. Lewis is past president of the Denver and Colorado Medical Society and is currently a member of the Board of Directors of Copic Insurance Company.*



# Soon, your practice could be run from here.

Most people agree that the U.S. health care system needs significant change. And if a single-payor, national system is adopted, it will change.

Some proposals under consideration would put the government in charge of America's health care. That kind of radical change could affect your freedom to make decisions in administering patient care. It could affect the way you're compensated. And how you use medical technology.

If you find these kinds of changes hard to swallow, maybe you should support a proposal that will build on what's good about America's health care system. And change what's not. A plan like Health Access America.

Developed by the American Medical Association, Health Access America was designed to preserve the integrity of the system while improving programs like Medicare and Medicaid, and requiring employer-sponsored health plans.

So while there's still time, speak for yourself. Join the AMA's call for reform. Call 1-800-AMA-3211 for more information on Health Access America.

## Health Access America

The AMA proposal to improve access to affordable, quality health care.

## American Medical Association

Physicians dedicated to the health of America







# ethics and "Managed Health Care"

by Bill Pierson, Managing Editor

It was January, 1977, and there had been increasing talk about the rapid escalation in the cost of medical care. The hue and cry became one of "cost-cutting" or, at least, "cost-containment" in the "health care industry." Finger-pointing and blame were common, but little concrete evidence existed that anything was being done to stop the upward spiral. Physicians were often targeted as the primary cause of rising health care costs.

Out of the clamor came a call from Frederick A. Lewis, M.D., President of the Denver Medical Society, for persons interested in devoting time and effort to deal with the issue of cost-cutting/cost-containment; there would be a committee to "Explore moral, ethical and philosophical decisions related to the cost of medical care."

The committee, under the chairmanship of J. Phillip Nelson, M.D., would meet of an evening over a period of months and would be made up of representatives of physicians, the clergy, labor, business, hospital administrators, medical schools, nursing homes, consumer advocates, health insurance industry, government, homemakers, senior citizens, lawyers, social workers, health economists and the news media.

On February 15, 1977, the committee held its first meeting to explore in detail, the various moral, ethical and philosophical implications and principles related to the cost of providing medical care; and, at the conclusion of deliberations, to prepare a statement summarizing the Committee's discussions and outlining ethical and moral guidelines to be considered in the appropriate allocation of medical care resources, which may, in fact, determine "who shall live."

The Committee met regularly over a total of six months, including creation of subcommittees for more detailed study of special areas. The first four meetings began with a formal presentation of background material relative to a specific area of discussion. The remainder of the meetings were devoted

*Editor's Note: Granted, fifteen years is not a very long period of time; but the period is interesting when you look back and see how much (or how little) has changed during those years. "Managed Care," a modern-day axiom, seems to be little more to this writer than a glossy version of health care rationing. In any event, during fifteen years, the names have changed, but little else has.*

BP

to group discussions of the specific topic areas. In addition, a reading list was provided for use by Committee members to stimulate thought and discussion.

In the 15 years since the committee's inception, what has happened to health care and related costs (cost containment)?

1. HMO comes on the scene as major cost-cutting effort and fast becomes an integral part of the total health care delivery system.
2. Total health care costs continue to escalate, while health insurance rates have risen prohibitively and insurance coverage has decreased markedly.
3. Health care costs further increased by the onset of a "malpractice crisis" in the late 1970s, and

ensuing discussion of an increase in "defensive medicine."

4. Growing fear of "bankrupting" the Medicare/Medicaid programs, while Congress continues to hack away at benefits and physician reimbursement.
5. "Pre-admittance review" becomes household term in matters of insurance coverage.
6. Legislators assume an increased role in the regulation of health care and related budget.
7. Discussion of adopting the "British" or "Canadian" system of nationalized health care continues to increase.
8. Business/industrial coalitions cut employee health care benefits, providing "alternative" insurance packages and contractual health care services.
9. Former Colorado Governor Richard Lamm becomes the "health care guru" gaining wide notoriety through the "duty to die" concept.
10. Managed Health Care emerges out of creation of HMOs, PPOs and other efforts to "direct" health care delivery and costs.
11. Oregon the first state to talk openly of "health care rationing" legislation. Colorado followed suit with proposed "health care prioritization."
12. (Fill in your own observations; if you put your mind to it, you'll need 2 to 3 additional pages.)

Next, look at the following pages and see what the 1977 committee decided.

**Date:** February 15, 1977

**Time:** 6:00 p.m.

**Place:** Denver Medical Society, 1601 E. 19th Avenue, Denver, CO

**Purpose:** Meeting, *Committee to Explore Moral, Ethical and Philosophic Decisions Related to the Cost of Medical Care*;

**Chairman:** J. Phillip Nelson, M.D.

**Committee Members:**

Willis L. Bennett, M.D., Vice President, Professional Programs Division, Blue Cross/Blue Shield

Hilary Connor, M.D., Ass't. Surgeon General, Region VIII, USDHEW

John W. Cowee, Ph.D., Chancellor, University of Colorado Medical Center

Charles Friedman, Esq., Past President, Trial Lawyers Association

F. A. Garcia, M.D., Past President, Denver Medical Society

Judy Gold, Administrative Aide, Denver City Council

Martha Hansen, Second Vice President, Denver League of Women Voters

Floyd Harrison, Jr., Executive Director, Baptist Nursing Home Association

Emmet Heitler, Former Chairman, Executive Committee, Samsonite Corporation

Richard Henry, D.D., Minister, First Unitarian Church

Wayne Herhold, Administrator, St. Luke's Hospital

William Hynes, Ph.D., Professor of Philosophy and Religion, Regis College

James E. Kelley, Editorial Department, The Denver Post

James L. Kurowski, M.D., Medical Director, Eastside Neighborhood Health Center

Frederick A. Lewis, M.D., President, Denver Medical Society

Mike McNeill, President, Denver Firefighters Local 558, IAFF

Peter A. Morstad, Executive Director, Denver Medical Society

Felicia Muftic, Director, Metro District Attorneys Consumer Affairs Office

Kaye Murphy, President, Denver Medical Society Auxiliary

William Pierson, News Director, Armstrong Broadcasting Company

Stuart Plummer, Chaplain, Presbyterian Medical Center

Cyril Roseman, Ph.D., Associate Professor, Philosophy and Religion, Colorado Women's College

Earl S. Stone, D.D., Rabbi, Temple Emanuel

Dana Wilbanks, Ph.D., Professor, Iliff School of Theology

**Purpose of the Committee:** To explore in detail, the various moral, ethical and philosophical implications and principles related to the cost of providing medical care; and, at the conclusion of deliberations, to prepare a statement summarizing the Committee's discussions and outlining ethical and moral guidelines to be considered in the appropriate allocation of medical care resources, which may, in fact, determine "who shall live."

**Structure and composition of the Committee:** The Committee was composed of persons representing a variety of interests concerned with health and medical care and their related costs. The Committee's Chairman was appointed by the President of the Denver Medical Society. The Committee met regularly over a total of six months, including creation of subcommittees for more detailed study of special areas. The first four meetings began with a formal presentation of background material relative to a specific area of discussion. The remainder of the meetings were devoted to group discussions of the specific topic areas. In addition, a reading list was provided for use by Committee members to stimulate thought and discussion.

**Summary of Deliberations:** During the past twenty-five years there has been an inexorable rise in the cost of medical care in the United States and other Western Countries. The reasons for these increased costs are multiple. Principal factors are general inflation, increased numbers of elderly requiring more care, increasingly complex and diverse technology, unnecessary procedures, duplicative facilities, defensive medicine, increasing salary demands and change from acute episodic care to maintenance of chronic, degenerative illness. Underlying these factors has been the increasing availability of, and demand for, medical care on the part of the general populace because of third-party payment mechanisms which have substantially released both physician and patient from direct fiscal responsibility for care. Reason would dictate that an annual inflation rate of 14-15% for medical care costs is intolerable. Concerted efforts towards cost containment implying some form of rationing will be necessary to at least reduce this inflation rate to levels comparable to the general inflation rate.

The committee was constituted to explore the ethical ramifications of the premise that rationing of medical care will be necessary. This assumption implies that availability and/or quality of medical care will have to be curtailed and raises the problem of how to impose these reductions with fairness, justice and compassion. Since all of society pays these costs through taxes or insurance payments and since the consequences of any form of rationing could affect almost any member of society, the problem of determining ethical guidelines for the application of rationing should be made by society at large and not just the medical profession; hence, the composition of the Committee.

Since medicine and medical care are only a part of society, the Committee's deliberations occurred against the background of formal presentations by Committee members on the general historical topics of: ethics, economics, medical care delivery system, medical ethics, law and religion.

(Continued)



Finally, small discussion groups were formed in order to answer questions raised in previous sessions and in individually written statements dealing with specific current ethical problems. The premise for these discussions was: Some form of medical care rationing has always existed but now needs re-examination because of increasing medical care costs. There are a number of difficult ethical decisions implicit in determining a reasonable, compassionate system of medical care rationing. The assumptions underlying this premise were:

1. Public policy and acceptance of the idea that "health care is a right and not a privilege" has resulted in increased demand for, and access to, provision of medical care.
2. Prior to large scale "insurances," rationing was based largely on the ability of the patient to pay. With the advent of the third-party payor system, patients have been largely insulated from direct economic responsibility for their medical care.
3. During the past twenty-five years, technologic developments have resulted in the capacity for prolongation of life and have raised questions related to (1) quality of life for the individual and (2) cost-benefit to the patient, family or community.

Policy issues were identified and a Committee consensus concerning these issues was reached.

**Going back 15 years,** what were the Committee's conclusions? Primary among them were the following consensus statements:

NOTE: Read the following policy issues and check just which, if any, of the consensus opinions have been acted upon or fulfilled.

☐ **Policy Issue:** Is there a need for re-evaluation of attitudes and value systems regarding health, sickness and death in our society?  
**Consensus:** Yes, they need to be re-evaluated and revised and there must be leeway for differences. The medical profession needs to actively join in this re-assessment.

☐ **Policy Issue:** What are the limitations, humaneness and legal implications of extraordinary means of life support ("heroic" medicine)?  
**Consensus:** ("Heroic" medicine) should not be automatic and in some instances may be inhumane. It should take into account the physical, mental and spiritual status of the patient and members of the family. There are both civil and criminal implications and the legal process should be appropriately re-assessed.

☐ **Policy Issue:** Since there cannot be unlimited medical care for all, should medical care be limited to selected populations? If care is limited, should this be decided on the basis of productivity to society, on the ability to pay, on the preferences of patient/family/physician, on the predictability of outcome of treatment or some other method?

**Consensus:** There should be a commitment for basic medical care for the total population with elimination of ability to pay as an eligibility criterion. The preferences of patient, family and physician must be respected. The patient must be informed concerning the efficacy and cost of various treatments in order to make a choice. It is recognized that there will always be some inequities in access based on such factors as age, geographic location, social status, productivity to society, etc. If resources become severely limited, the possibility of random selection such as lottery might have to be considered to achieve equity.

☐ **Policy Issue:** Are changes needed in medical education and, if so, what is the nature of these changes?  
**Consensus:** There is a problem with the current role model in medical education because of heavy emphasis on research. There should be renewed emphasis on the clinician's role.

☐ **Policy Issue:** On what criteria should decisions be made on research with regard to funding, quantity and control?

**Consensus:** Research is important to a vital society and medical care system but its basic goal should be clearly to improve human well being. Because of probable funding limitations, research will be required to be more creative and accountable. The technologies which research develops will need very clear guidelines for application.

☐ **Policy Issue:** Do we need more physicians and physician extenders?  
**Consensus:** Because of substantial increases in training of physicians (100% during the past seven years) there will be a substantial increase in the number of practicing physicians. They, and physician extenders, can be expected to generate more services to more people and, therefore, more costs. The training of physicians should be predicated on geographical and specialty needs (which require precise manpower studies) and upon the impact of physicians and physician extenders on total and unit costs (which implies the need for precise cost-effectiveness studies).

(Continued)

- ❑ **Policy Issue:** Can we, or should we, develop mechanisms to establish cost/benefit ratios before permitting purchase of costly equipment or payment for costly services?

**Consensus:** In general, the Committee felt that cost/benefit ratios would be an effective guide for health resource allocation and should be encouraged. Public sector hospitals already operate under budgetary controls and with only mixed results at best. Legislative efforts to contain costs are probably worthwhile, but there is a question of fairness in singling out one area of society for such control. Many people with the financial means would circumvent regulations and buy better services.

- ❑ **Policy Issue:** Who should participate in arriving at decisions related to rationing of medical care?

**Consensus:** The Committee was unanimous in the opinion that all of the "public" should be informed about issues in containing the cost of medical care. The development of health education for young people was thought to be particularly important.

- ❑ **Policy Issue:** Could modification of the insurance system (such as elimination of first-dollar coverage and requiring deductible) affect the rationing process?

**Consensus:** Yes. The insurance system, with its incentives and controls, needs review and modification and both labor and industry must appreciate their significance in this process.

- ❑ **Policy Issue:** Are we maximizing present health care resources?

**Consensus:** No. There is a need for centralizing tertiary care and decentralizing primary care. This reorganization of the medical care delivery system will probably require development of a national health policy, coordinated and implemented by local planning and regulatory bodies. This

implies the need for coordinated efforts at the national level, of federal agencies charged with the implementation of health care delivery systems.

- ❑ **Policy Issue:** Who should develop criteria for rationing health care?

**Consensus:** The community, through the political process. This implies that many sectors of society must contribute ideas and that decisions will be made by groups under a system of checks and balances.

- ❑ **Policy Issue:** How should the rationing process proceed?

**Consensus:** The rationing process should occur in the public arena and specifically in the insurance process, the planning process (such as Health Systems Agencies and manpower allocation) and in medical education. As a practical matter, it will be necessary to have elected representatives approve legislation and allocate money for an effective health care system.

At the conclusion of the Committee's deliberations, the Committee recommended the following as among the most important general areas for further discussion regarding the ethics, morals and philosophy of medical care cost allocations:

- A. Systems for delivery of care
- B. Access to medical care
- C. The quality of care
- D. Research
- E. The regulation of technological innovation and application
- F. The production of medical manpower
- G. Insurance mechanisms
- H. The mystique of the patient-physician relationship
- I. Preventive vs. maintenance vs. acute care.

Among the most important specific areas for further discussion regarding the ethics, morals and philosophy of medical cost allocations were:

- A. Premature and newborn care
- B. Cancer

- C. Old age
- D. Coronary artery disease
- E. New joints
- F. Kidney disease-mechanical life sustenance
- H. Mental illness and suicide
- I. Accidents
- J. Alcohol, tobacco and other drug abuse
- K. Wellness vs. illness.

## EXERCISE YOUR RIGHT



## VOTE

**in the Primary Election  
Tuesday, March 3, 1992**

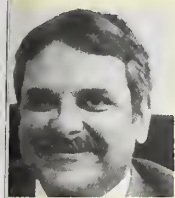
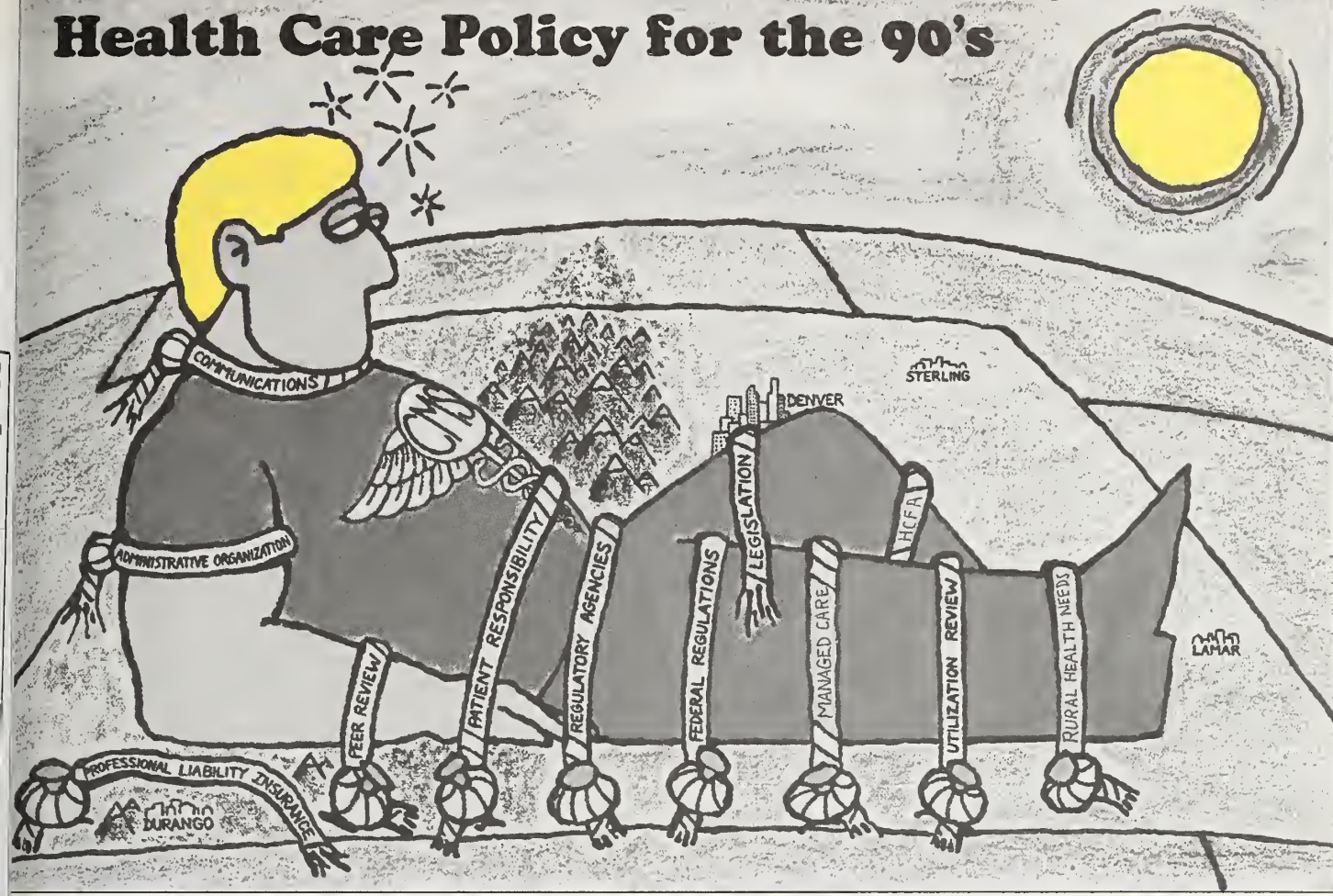
**Polls are open from  
7 am to 7 pm**

**Call your County  
Elections Commission  
for information on  
polling places**

**APPLY for an absentee  
ballot by February 28**



# Health Care Policy for the 90's



G. Butler, III, MD

Many physicians are having trouble. From this 1987 piece of art (above) you can see that things haven't changed much, even though we've made some roads in communications, CMS organization, legislation and professional liability insurance. Colorado Medical Society, as a group, and individual physicians are still having the same troubles but with growing pressure. The state legislature and Congress are both building to a crescendo in their respective chambers over health care policy.

*Harrison G. Butler, III, MD*

Harrison G. Butler, III, MD  
President  
Colorado Medical Society

The heat is on at the state and federal level... pushing physicians and health care professionals harder and harder to come up with some kind of health care reform. Re-inventing the wheel.

That's why we dug ol' "Golliver" out of our publication archives and re-published him here. That's also why the CMS has structured some educational activities at this year's Interim Meeting centered around Health Care Policy.

Get a handle on the changes in Medicare reimbursement and coding, current legislation, corporate health: the hot issues of 1992.



Sandra L. Maloney

Plus, you'll be able to meet with colleagues to exchange ideas. You'll definitely want to be there.

Check the following pages for more information and **send in your registration today.** Without it, we won't know you're coming.

You may be disappointed to find there's no room in the events you wanted to attend.

*Sandra L. Maloney*

Sandra L. Maloney  
Executive Director  
Colorado Medical Society



# Health Care Policy for the 90's

## Colorado Medical Society Interim Meeting-March 6-8, 1992

Sheraton Denver Tech Center  
4900 DTC Parkway  
Denver, Colorado  
Schedule of Events

### FRIDAY, MARCH 6, 1992

(Friday events to be held at CMS offices, 7800 E. Dorado  
Place in Englewood, Colorado)

1:00 pm Corporate Health Initiatives  
Panel Discussion (sponsored by  
Corporate Health Committee)

Medicare Payment Reform (1:00 pm)

Moderator

**Harrison G. Butler, III, MD**  
President, Colorado Medical Society

Featured

**Ray Painter, MD**  
CMS Delegate to AMA  
**Grant Steffen, MD**  
Medical Director, Medicare Part B  
**M. Lynne Northcutt**  
Program Manager  
CMS Department of Health Care Financing

Panel Discussion (2:00 pm)

Moderator

**Harrison G. Butler, III, MD**  
President, Colorado Medical Society

Overview

**Ronald R. Loeppke, MD**  
Chairman, CMS Corporate Health Committee

Business Viewpoint

**Ms. Lucille "Lucky" Gallagher**  
Vice President—Risk Management  
Monfort, Inc.

Legal Viewpoint

**Mr. Jeff Bedingfield**  
Bedingfield & Associates

Physician Viewpoint

**Leigh Truitt, MD**  
President-Elect, Colorado Medical Society

5:30 pm Welcome Reception/Open House

### SATURDAY, MARCH 7, 1992

7:00 am-5:00 pm Registration  
7:00 am-8:30 am Reference Committee Breakfast  
8:30 am-9:00 am Credentials Committee  
9:00 am-9:30 am House of Delegates  
9:30 am-11:45 am General Membership Meeting  
12:00 noon-1:30 pm Luncheon—Dr. Patricia Nolan  
Executive Director, Colorado  
Department of Health  
1:30 pm-4:00 pm Reference Committee on Board of  
Directors/Constitution, Bylaws and  
Credentials  
1:30 pm-4:00 pm Reference Committee Physician/  
Patient Advocacy  
3:30 pm-6:00 pm Reference Committee on Legisla-  
tion/Professional Education  
3:30 pm-6:00 pm Reference Committee on Commu-  
nity Health Issues/Medical Service

### SUNDAY, MARCH 8, 1992

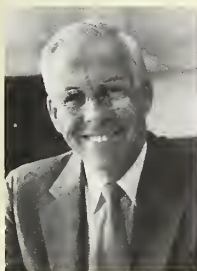
7:00 am-11:00 am Registration  
7:00 am-8:15 am Caucus Breakfasts  
8:30 am-12:00 noon House of Delegates





## Health Care Policy for the 90's

# Dr. Jim Todd to Keynote Interim Meeting



*James S. Todd, MD  
Executive Vice President  
American Medical Association*

James S. Todd, MD, Executive Vice President of the American Medical Association, will be the Keynote Speaker at this year's Interim Meeting of the Colorado Medical Society. Dr. Todd will speak at the General Membership meeting Saturday morning March 7.

Dr. Todd, a general surgeon from Ridgewood, New Jersey, joined the American Medical Association as Senior Deputy Executive Vice President on February 12, 1985. He was a member of the Board of Trustees from July, 1980, to June, 1984, as well as a Commissioner to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) from 1982-1985.

Born on July 9, 1931, Doctor Todd graduated cum laude both from Harvard College and Harvard Medical School. He interned and served his residency in surgery at Columbia Presbyterian Medical Center, becoming Chief Resident in 1963. He is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. From 1977-1985 he was Chairman of the Board of the New Jersey State Medical Underwriters, Inc., and is a Past President of

the Physician Insurers Association of America.

Doctor Todd has been a Director of the Institute of Society, Ethics, and the Life Sciences (Hastings Center) and was Councillor-at-Large of the Harvard Medical Alumni Association. His service to the community includes: Committee to Establish Guidelines for the Care of Comatose Patients, State of New Jersey, 1977; recipient of the Edward J. Ill Distinguished Physician Award of the New Jersey Academy of Medicine in 1980 and the Distinguished Service Award of the New Jersey Hospital Association.

He has served as Trustee, later President, of the Bergen County (New Jersey) Medical Society, Chairman of the New Jersey Delegation to the AMA House of Delegates, and Chairman of the Ad Hoc Committee to Review the AMA's Principles of Medical Ethics.

Doctor Todd has published numerous articles dealing with health care and professional liability. He has been Executive Vice President of the American Medical Association since 1990.



# Health Care Policy for the 90's

## Featured Speakers For Interim Meeting 1992

### Medicare Physician Payment

**Reform** will be the hot topic for discussion in a special one hour program on Friday, March 6, during the Colorado Medical Society Interim Meeting.

The program, which begins at 1:00 pm will be moderated by Harrison G. Butler, III, MD, President of the Colorado Medical Society and will feature Ray Painter, MD, CMS Delegate to AMA; Grant Steffen, MD, Medical Director for Medicare Part B and Lynne Northcutt, Program Manager, CMS Department of Health Care Financing. After brief introductory remarks, the remainder of the program will be devoted to answering questions on Medicare from the audience.

**Leigh Truitt, MD**, President-Elect of the Colorado Medical Society, will be one of the panelists in a seminar on Corporate Health Initiatives, Friday, March 6, as part of the 1992 Interim Meeting.

Dr. Truitt is a practicing primary care physician with broad experience in managed care. In addition, he has a Master's degree in Business Administration. He has experience in utilization review, management and consultation.

Currently, Dr. Truitt is President of *Total Care Network*, a provider group organized to deliver capitated care at various levels. He has developed and organized various medical business arrangements with considerable success.

**Jeffrey T. Bedingfield, Esq.**, is a shareholder in the firm of Bedingfield & Associates, PC of Greeley, Colorado. Mr. Bedingfield obtained his undergraduate degree from Pacific Lutheran University (BA 1976) and his law degree from Northwestern School of Law of Lewis

and Clark College (JD 1980). Mr. Bedingfield's law practice emphasizes corporate and business law and involves health law in a business context. Mr. Bedingfield is a member of the American Bar Association (Business Law Section and Forum Committee on Health Law), Colorado Bar Association (Corporate Law Section and Forum Committee on Health Law), and National Health Lawyers Association.

**Lucille A. Gallagher, ARM**, is Vice President of Risk Management for Monfort, Inc. and the Red Meat Companies Division of ConAgra, Inc. Lucille is responsible for Risk Management, Employee Benefits, Safety, Ergonomics and Health and Wellness Services for the Red Meat Division, as well as Vice President—Operations of Monfort's wholly owned captive insurance company.

In 1986-1987, Ms. Gallagher served as President of the Rocky Mountain Chapter RIMS (Risk and Insurance Management Society, Inc.). Prior to that, she served as Vice President and Secretary, as well as chairing various committees.

During 1989, Colorado Governor Roy Romer appointed Ms. Gallagher to his task force on insurance to aid in the selection of the new Colorado Insurance Commissioner and develop a white paper on priority issues for the insurance department. She served for three years on the Insurance Board, appointed by Governor Richard Lamm, from 1982-1985. She currently serves on the Governor's Workers' Compensation Oversight Task Force, appointed by Governor Roy Romer.

She currently serves her community as President of the Board of Directors of Arapahoe House, the largest non-profit alcohol and drug treatment center in Colorado, and a member of the Greeley Convention and Visitors Bureau Advisory Board.





# Health Care Policy for the 90's

ID# \_\_\_\_\_ (Office Use) Delegate # \_\_\_\_\_

## REGISTRATION FORM

Please fill out and mail to: Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550  
or FAX to (303) 771-8657

1992 Interim Meeting of the Colorado Medical Society, March 6-8, 1992, Sheraton Hotel, Denver Tech Center

Name \_\_\_\_\_ ☐ MD ☐ DO ☐ Other \_\_\_\_\_

Component Society \_\_\_\_\_ Office Phone \_\_\_\_\_

### STATUS (please check all that apply)

<input type="checkbox"/> Delegate	<input type="checkbox"/> Council Chair	<input type="checkbox"/> 25 year physician	<input type="checkbox"/> AMA Member	<input type="checkbox"/> Component Society President	<input type="checkbox"/> Women in Medicine Section
<input type="checkbox"/> Alternate	<input type="checkbox"/> Committee Chair	<input type="checkbox"/> 40 year physician	<input type="checkbox"/> AMA Delegate	<input type="checkbox"/> Specialty Society Representative	<input type="checkbox"/> Young Physicians Section
<input type="checkbox"/> CMS Past President	<input type="checkbox"/> Peer Review (Grievance) Committee	<input type="checkbox"/> 50 year physician	<input type="checkbox"/> AMA Alternate	<input type="checkbox"/> Compac 99+	<input type="checkbox"/> Resident Physicians Section
<input type="checkbox"/> CMS Board	<input type="checkbox"/> Credentials Committee	Non-Member <input type="checkbox"/> Program Only (\$25)	<input type="checkbox"/> Medical Executive	<input type="checkbox"/> AMPAC	<input type="checkbox"/> Hospital Medical Staff Section
<input type="checkbox"/> Honorary Member	<input type="checkbox"/> Reference Committee	<input type="checkbox"/> Copic	<input type="checkbox"/> Program Speaker	<input type="checkbox"/> Press	<input type="checkbox"/> Other _____

### AUXILIARY REGISTRATION

Name \_\_\_\_\_ County \_\_\_\_\_ Office Held \_\_\_\_\_

### RESERVATIONS FOR EVENTS AND MEETINGS

Reservation deadline February 26. Reservations accepted on a first-come first served basis (may be limited for some programs).

#### FRIDAY, MARCH 6, 1992

(EVENTS HELD AT CMS OFFICES, 7800 E. DORADO PL, ENGLEWOOD)

		Number of Reservations	Amount Enclosed	Office Use
1:00 pm	Corporate Health Initiatives Seminar (includes RBRVS update)	_____	Complimentary	<input type="checkbox"/>
5:30 pm	Welcome Reception & Open House	_____	Complimentary	<input type="checkbox"/>

#### SATURDAY, MARCH 7, 1992

(EVENTS HELD AT SHERATON DENVER TECH CENTER)

7:30 am	Reference Committee Breakfast	_____	Complimentary	<input type="checkbox"/>
12 Noon	Luncheon —Dr. Patricia Nolan Executive Director, Colorado Department of Health	_____	Complimentary	<input type="checkbox"/>

Please use the hotel reservation form (see next page) to make your reservations directly with the Sheraton Denver Tech Center Hotel. The deadline for reservations is February 21. The preferred rate will be extended to CMS members on a space available basis after February 21. *Please submit a registration form if you plan to attend this Interim Meeting.* We're delighted to receive it by mail, fax or phone. We can check you in more quickly and efficiently if you've pre-registered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!!



# Health Care Policy for the 90's

## Establishing CMS Policy

It is the responsibility of the CMS House of Delegates to set policy for the society. It is of critical importance that each member convey his opinions to the House so that established policy represents the majority viewpoint. Two easy ways for you to share your opinions are 1) testify before a reference committee on March 7 or 2) ask a delegate from your component society to convey your opinions to the reference committee.

You *can* make a difference on issues such as the following:

### **RES-1-P - Non-Smoking Ordinances/Legislation**

.....RESOLVED, that the Colorado Medical Society urge government officials and legislators to enact ordinances or legislation to prohibit smoking in Coors Stadium, Mile High Stadium, Stapleton International Airport, Denver International Airport and all other municipal buildings and facilities.

### **RES-5-P - HIV Testing**

.....RESOLVED, that the Colorado Medical Society (CMS) expresses unanimous opposition to mandatory HIV testing for physicians and other health care workers, and be it further

.....RESOLVED, that all CMS Officers, Board Members and staff exercise extreme caution when making any public statement on behalf of CMS regarding the risk of physician to patient transmission of HIV and be it further

.....RESOLVED, that CMS support the absolute confidentiality of HIV status of any CMS member as private data, part of the medical record, and be it further

.....RESOLVED, that CMS pledges its full resources to support the premise that a physician practicing currently accepted Standards of Universal Precautions as outlined by the Center for Diseases Control, should be guaranteed the right to practice medicine regardless of her/his HIV status, and be it further

.....RESOLVED, that CMS pledge its full support to any CMS member denied the right to practice medicine based on HIV+ status.

### **RES-13-P - HIV Testing in Patients**

.....RESOLVED, that the Colorado Medical Society will pursue public education efforts to permit physicians to test patients for HIV infection consistent with the way in which other infectious diseases are diagnosed and treated. This would render the use of general patient consent as acceptable authorization to test for HIV infection when medically justified.

### **RES-8-A - Protocol for Physicians to Recognize, Report, Treat and Refer Victims of Domestic Abuse.**

.....RESOLVED, the Colorado Medical Society will develop a model protocol for office based physicians on recognizing, reporting, treating and referring to appropriate resources, victims of domestic abuse. (The Denver Medical Society submits its own protocol, developed for Metro Denver based physicians, as a model for CMS consideration.)

**Reference Committee Hearings** are scheduled on Saturday, March 7, as follows:

- 1:30 p.m. Reference Committee on Board of Directors/Constitution and Bylaws  
Reference Committee on Physician/Patient Advocacy
- 3:30 p.m. Reference Committee on Legislation/Professional Education  
Reference Committee on Community Health Issues/Medical Service

**Note:** These are only some of the early resolutions. Other issues may come up for debate at the meeting as well. Please complete the registration form on the reverse and return it today. This is your chance to get involved in making a difference for health care policy for the 90's.





# Health Care Policy for the 90's

## Sheraton Denver Tech Center

4900 DTC Parkway  
Denver, Colorado 80237  
(303) 779-1100 (800) 552-7030 (outside Colorado)

### ACCOMMODATION RESERVATION REQUEST

PLEASE PRINT:

Name \_\_\_\_\_ Organization Name Colorado Medical Society \_\_\_\_\_  
Address \_\_\_\_\_ Meeting Dates March 6-8, 1992 \_\_\_\_\_  
City \_\_\_\_\_ Q-Name MEDD \_\_\_\_\_  
State/Country \_\_\_\_\_ Guest Arrival Date \_\_\_\_\_  
Zip Code \_\_\_\_\_ Guest Departure Date \_\_\_\_\_  
Business Hours Telephone \_\_\_\_\_ No. of Persons \_\_\_\_\_

Room type, location and rate subject to availability at time of request. *Indicate preference and mail early.*

#### Guestroom:

1 person \$70.00

☐ 1 Bed

Suites and concierge floor

2 persons \$75.00

☐ 2 Beds

available upon request.

3 persons \$85.00

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Please contact hotel

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(1 Bed Only)

directly for rates.

☐ Non-Smoking Room (subject to limited availability).

To guarantee room for arrival after 6 p.m., please complete A or B:

(A) Amount of enclosed check \$ \_\_\_\_\_

(B) ☐ VISA ☐ Mastercard ☐ American Express ☐ Diners Club ☐ Discover

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

*Confirmation is based on scheduled arrival date availability. All rates subject to tax. Currently 12%.*

*Request and deposit must be received by February 21, 1992. Deposit refunded if cancellation is received 48 hours prior to arrival. Check-in time and guestroom availability is 4:00 p.m. Check-out time is 1 p.m. Please arrange travel plans accordingly. Baggage storage available for earlier arrival.*



# Health Care Policy for the 90's

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by  
*Alan D. Rapp, MD, Chairman*  
*CMS Council on Legislation*  
*and*  
*Sue Ellen Quam, Director*  
*Lorraine Koehn, Program Manager*  
*Department of Government Relations*

At the time of this writing, the state legislature has just completed its first week of work and already there are 30 bills which will be followed by CMS. The bills have been referred to the appropriate CMS councils and committees for consideration. The councils and committees are asked to recommend positions on the bills to the Council on Legislation. The council then considers the recommendations and recommends a position to the CMS Board of Directors. The exception to this rule is when the CMS House of Delegates has established policy on specific issues.

A CMS Legislative Digest is being prepared which will list all the proposals which are being followed by CMS plus the positions taken on the bill by the society. This digest will be forwarded to component medical societies, leadership, and key contacts on a bi-weekly basis and any CMS member may receive a copy of the digest by calling the CMS Department of Government Relations at 779-5455 or 1-800-654-5653, Ext 427.

Examples of listings in the January 15 issue of the legislative digest:

**SB 3, Concerning Patient Autonomy in Regard to the Making of Medical Treatment Decisions (Wham):** authorizes persons to make advance medical treatment decisions for another person who becomes unconscious or incapacitated. Specifies the requirements for making a medical durable power of attorney and states what directives may be incorporated in a medical durable power of attorney. Allows for the designation of a health care proxy to act on an incapacitated

patient's behalf when the patient has not executed a medical durable power of attorney and has no appointed health care agent. Provides for the execution of a cardiopulmonary resuscitation declaration (CPR declaration).

Bill Status: Assigned to Judiciary Committee  
 COL Position: Referred to Ethics Committee and Legal Counsel

**SB 49, Elimination of the Requirement That There Be An Alleged Violation of the Uniform Motor Vehicle Law Other Than A Safety Belt Violation Before a Law Enforcement Officer May Stop a Driver for Violation of the Safety Belt Law (Hopper):** Eliminates the requirement that citations for safety belt violations be issued only to drivers who have been stopped for an alleged violation of the Uniform Motor Vehicle Law other than the safety belt law.

Bill Status: Passed Senate HEWI Committee on 1/15  
 CMS Position: Support

**SB 65, Reform of Methods for Providing Medical Assistance to Indigent Persons (Bird):** Specifies that the general assembly must act through legislation to enact a new method for providing health care to poor persons in the state.

Bill Status: Assigned to HEWI Committee  
 COL Position: Referred to Physician/Patient Advocacy

**HB 1010, Concerning the Practice of Lay Midwifery (Owen):** Decriminalizes the unlicensed practice of midwifery, by excluding it from the definition of the practice of medicine, while expressly not immunizing midwives from other civil or criminal liability. Requires registration of direct-entry ("lay") midwives with the division of registrations in the Department of Regulatory Agencies.

Bill Status: Assigned to Judiciary Committee  
 CMS Position: Oppose

**HB 1091 Authority of Physician Assistants (Chlouber):** Provides that a physician may delegate to a physician assistant the authority to implement any act under a medical plan, including initiating medical directives to professional and practical nurses, when the delegation is made pursuant to written protocol or the oral or written directions of the physician need not be on hospital premises to supervise the physician assistant when the delegated duties are being carried out.

Bill Status: Assigned to HEWI Committee  
 CMS Position: Referred to Council on Medical Services

The legislative committee to which a bill is assigned contributes greatly to whether the measure lives or dies. Bills of primary interest to CMS are generally assigned to the committees listed in the table on the following page.

The following are those committees and their members to which bills of interest to CMS are generally assigned

### Senate Bills

**Appropriations Committee:** Senators Bird, Chairman; Traylor, Vice-Chairman; Bishop, Owens, Pascoe, Rizzuto and Tebedo

**Business Affairs and Labor:** Senators Wattenberg, Chairman; Schaffer, Vice-Chairman; Ament, Mares, Martinez, Meiklejohn, Peterson, Schroeder, and Tebedo.

**Health, Environment, Welfare & Institutions (HEWI):** Senators Hopper, Chairman; Roberts, Vice-Chairman; Allison, Johnson, Mutzebaugh, Pascoe, and Wham.

**Judiciary:** Senators Wham, Chairman; Mutzebaugh, Vice-Chairman; Allison, Gallagher, Groff, Leeds, McCormick and Pastore.

### House Bills

**Appropriations Committee:** Representatives Grampsas, Chairman; Owen, Vice-Chairman; Blickensderfer, Hernandez, Jerke, Killian, Martin, Neale, Romero, Shoemaker, Tanner, Thiebaut.

**Business Affairs and Labor:** Representatives Schauer, Chairman; Chlouber, Vice-Chairman; Arveschoug, Dyer, Foster, Jones, Kopel, Lawrence, Owen, Tanner, Webb, Young.

**Health, Environment, Welfare & Institutions (HEWI):** Representatives Pankey, Chairman; Swenson, Vice-Chairman; Anderson, Coffman, Epps, R. Hernandez, Kerns, Killian, Kopel, Lawrence, Martin, Prinster.

**Judiciary:** Representatives Grant, Chairman; Fish, Vice-Chairman; Adkins, Benavidez, Blickensderfer, Epps, Fagan, R. Hernandez, Johnson, Knox, Ruddick, Tucker.

**NOTE:** Roger Walton has just published a revised edition of the book "Colorado, A Practical Guide to its Government and Politics". This is an excellent resource for all Colorado citizens interested in how state government operates. You may obtain a copy by writing Colorado Times Publishing Company, PO Box 150279, Lakewood, Colorado 80215-0279. Cost is \$12.95.

### HAVE YOU MOVED RECENTLY?

If you have moved since the last time you voted you may not be registered to vote in the Presidential Primary Election on March 3. Your Colorado Medical Political Action Committee (COMPAC) Board of Directors urges you to contact your county clerk of courts or election commission to confirm that you are registered.

### IMPORTANT ELECTION YEAR DATES

**February 7** Last day to affiliate to vote in the precinct caucus  
Last day to register to vote for the Presidential Primary Election

**February 28** Last day to apply for an application for an absentee ballot for the Presidential Primary Election  
Last day for absent voter to vote in county Clerk's office for the Presidential Primary Election

**March 3** Presidential Primary

**April 6** Precinct caucus day





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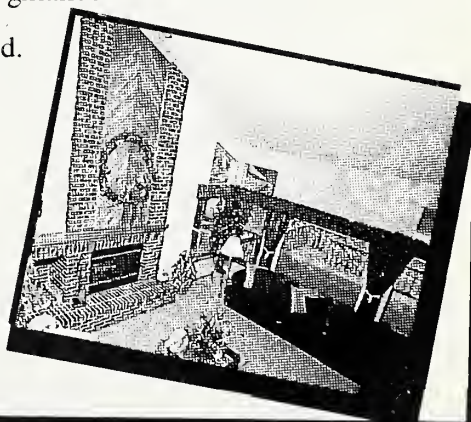


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A monthly report of current and on-going activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.

February, 1992

**COUNCIL ON COMMUNITY HEALTH ISSUES** continues to meet quarterly under the direction of chairperson, Dr. Sherri Laubach. At its November meeting the Council received a report from the Colorado Department of Health on the perinatal hepatitis B prevention program. The program is encouraging universal screening of all pregnant women, vaccination of all children of mothers who test positive and provision of the vaccine to those who are unable to afford it.

The Council heard from CMS lobbyist Sue Ellen Quam on a number of public health oriented bills which will be proposed during the 1992 legislative session. The Council will be prepared to review and provide recommendations on these bills to the Council on Legislation as well as to provide testimony before the legislature as requested by CMS lobbyists.

**MATERNAL AND CHILD HEALTH** committee has a new chairman, Dr. William Miller of Lakewood. He is interested in directing the efforts of the committee toward public health issues and developing a project for the committee. The problem of the lack of immunizations for all children in the state is being investigated. The committee will also continue to review other issues relating to maternal and child health. Members are being asked to make suggestions for projects and convenient meeting times.

**SPORTS MEDICINE COMMITTEE** is investigating the possibility of producing a video on helmet removal from injured players for distribution nation-wide. The recent article by Dr. Jim Kelly in JAMA on head injuries in sports has increased the requests for copies of the Committee's Guidelines for the Management of Concussions in Sports. These are being mailed throughout the United States. They are also being reprinted and distributed by the American Academy of Pediatrics.

The committee is also providing review of the rules and regulations being developed by the Board of Medical Examiners regarding practice guidelines for athletic trainers.

A statement regarding the transmission of HIV infection in sports is being developed.

**HEALTH CARE ISSUES OF SENIORS COMMITTEE** has not met since last spring. Membership recruitment is taking place to enlarge and diversify the committee. The Committee will begin to look at developing credentialing guidelines for geriatric physicians.

**MEDICAL INFORMATICS COMMITTEE** published a survey in the November issue of *Colorado Medicine* which will be used to determine the needs of physicians regarding effectively computerizing their offices.

**ENVIRONMENT COMMITTEE** is following the activities around the state regarding the burning of toxic waste in cement kilns. They also plan to look at the air pollution problem and the use of insecticides in the home.

At the October meeting of the **TASK FORCE ON AIDS**, members discussed plans for a proposed education campaign regarding the risks of iatrogenic transmission of HIV infection. This plan will include developing a CMS editorial board to work with the media; following the Colorado Code of Cooperation model for creating guidelines for reporting and public education; and a quarterly newsletter to keep the public updated on current CMS discussions, projects, and policies. A draft letter to begin the campaign was reviewed. These projects are somewhat on hold until such time as CMS policy is clearly defined. This Task Force drafted the AIDS survey recently mailed to member physicians.

Members of the Task Force worked with a coalition developed to refine Colorado Department of Health policy on HIV positive physicians. This policy as approved by the CMS Board was printed in December's *Colorado Medicine*.

The Task Force educational brochure entitled *Information for the Primary Care Physician about HIV Infection* has been mailed to all Colorado primary care physicians.

Per CMS policy as passed at the '91 Interim Meeting, the **DOMESTIC VIOLENCE TASK FORCE** HAS been created and held its first meeting in December. The Task Force has begun to outline its agenda and will be focusing on alleviating the barriers to physician intervention with patients involved in domestic violence.

**COUNCIL ON MEDICAL SERVICE** has not met since the Summer and has a meeting scheduled for January. Members will be reviewing the Interim Meeting resolution on Mid-level providers which was referred back to them for further work. In addition, a survey on the need for locum tenens services will be sent to all members via the February *Colorado Medicine*. The Council will review the survey results and make recommendations regarding the creation of a CMS locum tenens service.

Additionally, members of the Council represent CMS on each of the three newly funded programs for rural health care: The Colorado Rural Health Network Development Program, which just received \$241,000; the Colorado Rural Health Consortium, which was awarded a three-year \$115,000 grant to start a rural health resource center; and the Colorado Health Professions Loan Repayment Program which received a \$200,000 loan.

**EMERGENCY MEDICAL CARE PHYSICIAN ADVISORS COMMITTEE (EMCPAC)** members were apprised of the Rural Health Network Development Program's proposed guidelines for emergency services provided by rural primary care hospitals. The EMS Division is working closely with this coalition on the development of the guidelines.

At each meeting, the Committee receives reports from and provides input to the Colorado Department of Health EMS Division, the Colorado Trauma Institute and the BME.

**COLORADO HEALTH DATA COMMISSION TASK FORCE** has not had reason to meet recently. Information was, however, provided to the Task Force chairman to be used in discussions with the State Auditor's Office which is currently involved in a legislatively mandated audit of the Colorado Health Data Commission.

**COMMITTEE ON MEDICAL INDIGENCY** has been awaiting action by the Legislative Interim Committee on Medical Indigency prior to scheduling its next meeting.

**COUNCIL ON LEGISLATION** met in December and heard reports on current legislative efforts by Copic Insurance Company, Colorado Seat Belt Network, Colorado Department of Health, Colorado Commission of Family Medicine and Colorado Department of Social Services, who are dealing with Medicaid cost contain-

ment. Sue Ellen Quam, Director of the CMS Department of Government Relations, discussed several legislative issues with the Council, including auto insurance legislation, physicians infected with HIV, a business community coalition on health care costs and restricting access to abortion.

# Straight Talk

An educational magazine for Teens  
about AIDS/STDs

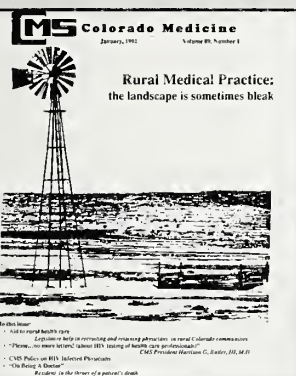
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PO Box 17550  
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or by calling Lynn Livingston at  
(303) 779-5455  
or  
1-800-654-5653  
\$2.75 per copy



# P ositive Progress on Rural Health Care

## Recoil!

Bill Pierson, Managing Editor  
Colorado Medicine



The Colorado Medical Society Medical Services Council, at its January 17th meeting, took issue with the January '92 cover of *Colorado Medicine* (above) because of the "negative attitude conveyed by this cover and the contents of the articles which go against the current discussions and focus of the Medical Society to develop alternative care solutions to rural Colorado's dilemma."

The editor duly notes the concern of the Council and the Council's good works in struggling to put a good face on rural medical practice in Colorado. However, little attention to a problem is garnered by painting over the problem with continuing reports of the good works. In addition, we're happy to note that, in any case, someone read about rural medicine in the January issue.

When there's a positive report, *Colorado Medicine* hopes to be the first to publish it, typical of the following locum tenens story.

One of the most perverse aspects of Colorado's rural health practice is the lack of necessary or adequate relief for the physician from his practice. Most of Colorado's country doctors are burdened with no physician to cover or take patients even for the shortest of times. It's a grinding, debilitating reality. The question of vacation, or even a day off, is seldom answered unless the physician calls in a professional locum tenens agency. And many times that is just impossible.

Rural physicians are faced with the problem of maintaining continuing medical education unless the accredited workshops and seminars are held in their immediate area. Even this is frustrating when the physician has to remain on call during the program.

Many of Colorado's rural areas have no established practices from which to draw relief, and medical care doesn't take a day off. Contrary to urban practice where there are often numerous practitioners in a specific specialty, many rural physicians don't enjoy that resource. Nor do they have the ability to share with fellow professionals, even on a casual day-to-day basis.

Rural medical practice in Colorado is rewarding and is not going begging. However, rural health is an area which requires all the help it can get, and Colorado Medical Society wants to help.

CMS knows the need exists and that there are few commercial locum tenens agencies with even fewer physicians available and willing to

serve. Two principal factors determine the availability and utilization of locum tenens: 1) the cost, and; 2) finding the physician available when needed or on a regular basis. Many physicians today would rather be practicing in the rural or small-town environment for a variety of reasons, one of these being the opportunity to practice more "traditional" medicine. However, rural medical roles are not practical for many because the areas most in need of (or where residents want their own) doctor simply cannot support a full-time practice.

Colorado is certainly not the only state faced with the rural health care problems. The state is unique in its population distribution between the eastern and western slopes, making rural medicine still more complicated because of weather and terrain extremes.

On the reverse side of this story is a questionnaire form. The form applies to all Colorado physicians, whether your practice is urban or rural, solo or group.

Please complete the form and return it to CMS. This is a member service organization, but the only manner in which CMS can help its members is through communication with and from its members. Your help will be greatly appreciated.

Turn the page and complete the questionnaire now!

# LOCUM TENENS

The Colorado Medical Society is considering the initiation of a locum tenens program that will assist physicians practicing in rural Colorado to enhance recruitment to underserved areas. If you think you might utilize the services of a locum tenens or if you are interested in serving in that capacity, please complete the following survey and return it to CMS, P. O. Box 17550, Denver, CO 80217-0550.

## Complete the following if you may be interested in the services of a locum tenens.

1. Name \_\_\_\_\_
2. Phone No. \_\_\_\_\_
3. Address \_\_\_\_\_
4. Specialty \_\_\_\_\_
5. Medical License # \_\_\_\_\_
6. Malpractice Insurer \_\_\_\_\_
7. Are you a CMS member? Yes ☐ No ☐
8. If you are not in solo practice please list the names of others who practice with you. \_\_\_\_\_  
\_\_\_\_\_
9. For what length of time do you anticipate needing a locum? (Check all that may apply)  
1-2 days ☐ 1 week or less ☐ 2-3 weeks vacation ☐  
emergencies (undetermined length) ☐ long-term need (1 month or longer) ☐
10. Describe your requirements for someone covering your practice \_\_\_\_\_  
\_\_\_\_\_
11. Please briefly describe your practice (i.e., setting, number of patients, scope of practice, hospital affiliation, etc.) \_\_\_\_\_  
\_\_\_\_\_
12. List your additional professional responsibilities (i.e., supervise mid-level providers, EMS physician advisor, etc.) \_\_\_\_\_  
\_\_\_\_\_

## Complete the following if you are interested in serving as a locum tenens.

1. Name \_\_\_\_\_
2. Phone No. \_\_\_\_\_
3. Address \_\_\_\_\_
4. Specialty \_\_\_\_\_
5. Medical License No. \_\_\_\_\_
6. Are you willing to assume responsibility for an OB practice? Yes ☐ No ☐
7. In what specialties are you Board Certified or Residency Trained? \_\_\_\_\_  
\_\_\_\_\_
8. Malpractice Insurer \_\_\_\_\_
9. Are you a CMS member? Yes ☐ No ☐
10. Please describe your requirements for placement (i.e., practice and community setting, scope of practice, length of assignment, financial arrangements, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## CPEP Wins National Award

Colorado Personalized Education for Physicians (CPEP) has been named the recipient of the **1992 W. C. Felch Award** of the Alliance for Continuing Medical Education (ACME). The annual award was presented at the ACME National meeting in New Orleans January 31st. Patrick G. Moran, M.D., CPEP's Medical Director, accepted the award. Moran told *C/M* the award carries a \$10,000 stipend which, he said, "will be utilized to continue development of assessment

instruments and learning resources" for physical interpersonal skills enhancement.

CPEP became operational in September, 1990

as the result of seven Colorado health care organizations interested in physician skill assessment and improvement.

The CPEP Executive Director is Roxanna Lynn Fredrickson.



Patrick G. Moran, M.D.

Editor:

I was interested in your column: "Doctor Volunteers: Getting Things Done" (*Colorado Medicine* 12/91; 374). I thought you might be interested in knowing that at the Johnson Clinic, which we started many years ago, we have all volunteer physicians. We have about 12 physicians who volunteer a half-day a week seeing patients and working with our nurse practitioner.

The clinic is supported by the Helen K. and Arthur E. Johnson Foundation. Even with volunteer physicians, because we accept Medicare Assignment, we have run a deficit each year.

I think the doctors really enjoy volunteering. We have a staff meeting once a month, which is kind of like an old home week since these are all doctors who have practiced in Denver for many years, most of whom have retired.

The Johnson Foundation is always interested in hearing that at our Christmas staff meeting, each of the doctors received a bottle of Scotch, which is their pay for the year.

I thought you would be interested in this group of volunteers who are doing a fantastic job for older patients, many of whom are in the low income bracket.

Very truly yours,

Frank B. McGlone, M.D.  
Executive Director  
Medical Care and Research Foundation

# CPHP

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Health Program

Dedicated  
to  
Physician Peer  
Assessment

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303-551-1045  
(502) 437-0442

CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health Program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and rehabilitating physically or emotionally distressed and impaired physicians.

# 9HEALTH FAIR

Endorsed by Colorado Medical Society

## 9Health Fair Slated for April

"Thank you for locating a trouble that would have been fatal if unattended."

*Recent 9Health Fair participant*

Since 1980, 9Health Fair has helped people take more responsibility for their own health. The Colorado Medical Society has endorsed the Fair for the past several years. The Fair provides basic screening and health education throughout Colorado. The 1992 Fair will be held April 4-12.

Eugene L. Weston, MD, a general, thoracic and vascular surgeon and member of the Board of Directors of the Colorado Medical Society, says, "The value of the fair is that it's strictly a screening. Any and all abnormalities are referred to the family physician for additional diagnostic work." Dr. Weston says that some physicians were hesitant about the program when it was first introduced by Clear Creek Valley Medical Society thirteen years ago, since they perceived it as possibly usurping the place of the primary care physician.

Dr. Weston, along with Dr. Robert Sawyer, serves on the Medical Advisory Board of the 9Health Fair. Among their many duties, says Dr. Weston, is ensuring that the purpose of the fair remains clear and unclouded. This year, for instance, they recommended against certain changes which were being advocated in the fair's format, because those changes would have involved some of the participants in diagnosis

*"It's strictly a screening."*

*Dr. Eugene Weston*

and/or non-scientific areas of health care.

One big advantage of the fair approach, says Dr. Weston, is that it is economical. He listed a series of tests performed on him recently for which his total bill was over \$400. At least one of those tests was offered by the health fair for only \$12, rather than the more than \$100 he paid. "Maybe I should have waited for the health fair" said Dr. Weston.

There are some encouraging success stories out of the 9Health Fair. Dr. Weston notes that ten thousand Jr. High and High School students were screened last fall in 39 Colorado schools. This year, they are also offering Corporate Health Fairs. Of several thousand tests, they recently found 74 positive Hemocults, 7 of which turned out to be cancer cases. Those seven people may owe their lives to early detection provided by the 9Health Fair. In a recent urology

screening recounted by Dr. Weston, 1,300 people were seen by urologists and 30 cancers were found.

That leaves plenty of room for more physicians to become involved in the Fair. Dr. Weston says they could always use more physician supervision at the sites. "It's not self serving," he says, "but it will

lead to more referrals." Whether patients come to you, or some other physician, they are doing something they might not have done if not for the 9Health Fair. Dr. Weston recommends calling Jill Moore, RN, BSN at 698-4455 to find out how you can get involved.

The 9Health Fair covers more than a hundred sites, where people 18 and over can obtain free basic screenings in height, weight, blood pressure, vision and colorectal. Some sites will also offer screenings of hearing, glaucoma, oral, foot, skinfold, breast exam, pap smear, body in balance, peripheral vascular disease, testicular cancer, prostate cancer and skin cancer.

The Fair will also feature a \$20 blood chemistry analysis, containing 29 components, including a coronary risk ratio. There is also an optional \$12 Prostate Specific Antigen Screening for men over 40.

For more information about 9Health Fair, call (303) 698-3799.



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# Passing of Friends

In the midst of finalizing one obituary, we learned, to our sorrow, that it was to be a double. Franklin D. Yoder, MD, MPH followed his wife Catherine in death on January 13, 1992.

Catherine had passed away in September, 1991.

"Frank" Yoder was known to his friends, not only here in Colorado, but also in Wyoming, Illinois and across the nation, as a tireless worker for the betterment of the public health and the medical profession. At his death at the age of 78, Dr. Yoder was still active in the (national) Accreditation Council for Continuing Medical Education, serving his second term as Vice Chairman of their Committee for Review and Recognition.

Dr. Yoder received his early education in Cheyenne, Wyoming schools, then received his bachelor's degree and Doctorate of Medicine from Northwestern University. He also held a Master of Public Health degree from the University of California at Berkeley.

After practicing family medicine in Cheyenne, Dr. Yoder entered the U.S. Army Air Force early in World II. In 1947, he was named head of the Wyoming Department of Public Health. In 1959, he was selected by the American Medical Association to be

Director of Environmental Medicine. He served as Director of the Illinois Department of Public Health for 12 years before moving to Greeley, Colorado where he directed the Weld County Health Department until 1979.



*Franklin D. Yoder, MD, MPH*

Among his many achievements, Dr. Yoder served as a member of the U.S. delegation to the World Health Organization in Geneva in 1957 and 1965. He received many awards and honors for his work in public health and higher

education. He was also active in community service.

While Dr. and Mrs. Yoder lived in Cheyenne Wyoming in the 1950's, Catherine served as President of the Women's Auxiliary of the Wyoming State Medical Society and board member of the Wyoming Council of Girl Scouts. While in Illinois, she had also served on the board of the Women's Auxiliary of the Illinois State Medical Society.

While President of the Colorado Medical Society Auxiliary in 1989-1990, Catherine Yoder worked on behalf of the medical profession on many fronts. She was active in influ-

encing legislation and urging other auxiliaries to do so. In her final letter as President, she told fellow auxiliary members that the campaign to increase use of seat belts was one of the valuable accomplishments of the organization.

Born Catherine L. Will in Herington Kansas, she married Franklin D. Yoder in 1945. Catherine had been valedictorian of Herington High School and earned a bachelor's degree from Sangamon State University in Springfield Illinois and a master's degree in English from the University of Northern Colorado.

Franklin Yoder, MD, shortly before his death, said of his wife,

"Catherine always believed in Colorado Medical Society Auxiliary's full support of the Colorado Medical Society and devoted her considerable energy toward it." Catherine, though, lauded the work of her fellow auxiliaries, saying "You have shown great leadership and strength in your communities and proven that there are many ways for us to bring better health



*Catherine L. (Will) Yoder*

and education to our individual areas, the state and the nation."

Memorial contributions may be made to the Franklin D. and Catherine Will Yoder Scholarship Fund in care of UNC Foundation Inc., Alumni and Foundation Center, Greeley, CO 80639.

# Physician Recognition Awards

The Colorado Medical Society joins the American Medical Association in recognizing the dedication of the following physicians to excellence in medical practice through their pursuit of Continuing Medical Education.

Fatima S Ahmed  
Frank E Bumgarner  
David B Burgess  
Donald L Coleman  
Shari J Fitzgerald  
Philip M Henbest  
Harlan D Hibbard  
Daniel A Hoffman  
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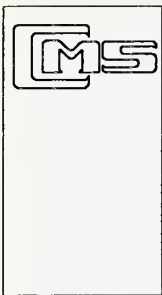
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# Diabetes, Cancer and Cardiovascular Disease

by Jackie Starr-Bocian  
Public Relations Specialist  
Colorado Department of Health

According to the Colorado Department of Health's Colorado Vital Statistics Report for 1989, the five leading causes of death in Colorado for that year were (in order), heart disease, cancer, cerebrovascular diseases, chronic obstructive pulmonary disease and unintentional injuries. These top five leading causes were responsible for 7 out of 10 deaths in Colorado in 1989.

As part of its mission, the Division of Prevention Programs produces periodic reports on Colorado's progress in reducing the major chronic diseases and in preventing injury in the state.

## The Diabetes Mortality Report for 1979-1988

The Diabetes Surveillance Project analyzed Colorado resident mortality data for 1979-1988 from death certificates with any mention of diabetes, either as an underlying factor or contributory cause of death (or both). It shows differences by sex, race and geographic variations. It will be used to identify high risk groups, target

## *"Cigarette cancers" continue to be a problem in Colorado...*

interventions and evaluate them.

Diabetes was the eighth leading cause of death in Colorado in 1988, killing Coloradans at the same rate today as it did ten years ago.

Although Colorado's standing is similar to or better than the rest of the nation in terms of both magnitude and age at death, this lack of improvement occurred at a time when the heart disease rate in Colorado dropped 11%. Additionally, during this same time, home glucose monitoring became available, more diabetes outpatient education programs were established and consensus on standards for outpatient education was attained.

For a copy of the report or further information about the Diabetes Control

Program, phone Sharon Michael at (303) 331-8300.

## Cancer in Colorado 1979-1988

In 1989, cancer was responsible for 42,169 years of potential life lost before age 75 in Colorado residents. Age adjusted average annual cancer incidence rates increased

steadily in the Denver metro area for both males (0.5% per year) and females (1% per year) during the 1980's. About one in three persons in Denver will develop some kind of invasive cancer before age 75.

"Cigarette cancers" continue to be a problem in Colorado, especially for women. Both incidence and mortality have generally increased over the decade for lung, larynx and pancreas cancers in women. Men, by contrast, show decreases in these cancers.

During the 1980's, breast cancer incidence also increased in Colorado (and the U. S.) about 3% per year, striking 1 in 9 women. However, cases are being diagnosed earlier and survival has improved. Prostate cancer has also



climbed 3% per year in Denver and in the rest of the country, and continues to be the most common cancer in men.

The Colorado Central Cancer Registry is hosting a two day meeting of the Colorado Tumor Registrars Association in late April. Interested health professionals are invited to attend. For information, contact Steve Peace at the Registry, (303) 331-8714. For a copy of the cancer report or further information about the Registry, contact Robin Bott or Jack Finch at (303) 331-8290.

## The Colorado Strategic Plan to Improve Cardiovascular Health, 1991-2000

Cardiovascular disease remains the leading cause of death in Colorado. The Colorado Cardiovascular Disease Prevention Coalition, formed in 1989, has three primary goals: to develop, carry out and evaluate the ten year strategic plan, to teach state and local health professionals about effective strategies for preventing and controlling cardiovascular disease; and to demonstrate the powerful effects of prevention projects rooted in community collaboration and tailored to populations who are at risk for cardiovascular disease.

Four specific products are already being developed as a result of the plan: a nutritional guide entitled *Peak Nutrition: Challenging Coloradans to New Heights*; a cardiovascular disease screening guide; "ExerDeck," a personalized exercise guide promoting cardiovascular fitness; and a Colorado Profile of Cardiovascular Risks.

The plan accents the need to reach minorities, low income people and the medically underserved, who suffer higher than average burdens of sickness and death from cardiovascular disease.

The plan highlights physical activity as one area with numerous benefits and high potential for Colorado. Physically inactive individuals have nearly *twice* the risk of developing coronary heart disease as those who are physically active.

For a copy of the Executive Summary or the full plan itself or more information about the project, phone Linda Dusenbury at (303) 331-8303.

# Copic COMMENT

## Good News Twice Over

A second 1992 distribution to Copic policyholders has been announced by the Copic Board of Directors. At its December 19th meeting, the Board announced that because of two favorable financial developments an "enhanced" distribution was approved.

The two events were:

- A new evaluation of Copic's reserves in mid-December by an actuarial firm indicated that settlements and judgments from the late 1980s will be even more favorable than had been anticipated earlier in 1991.
- The Board accepted improved reinsurance terms which are expected to produce substantial and ongoing savings to the company.

The combined returns to policyholders will now total \$6.1 million which, according to Copic's President and COO Larry Thrower, means that the average insured physician will realize a 14 percent reduction of his or her 1992 insurance costs.

The schedule for the distribution will be decided on at the company's annual meeting in February.

As Copic Insurance Company matures and adds to its Colorado experience and Colorado risk management training, the company operates more efficiently, thereby returning these operating costs to policyholders through the distribution program. And with maturity and improved claims experience comes the ability to contract more favorable reinsurance rates, translating into less cost for the individual policyholder.

## Dr. Greisman Newest Copic Board Member

Stewart L. Greisman, D.O., Medical Director of Emergency Medical Services for Swedish Medical Center, Englewood, has been elected to the Copic Board of Directors.

Dr. Greisman has been a member of the Colorado State Board of Medical Examiners for nearly five years; however, he has resigned that post in January to accept this new position with Copic. He was recently appointed Assistant Clinical Professor, Department of Surgery, Division of Emergency Medicine, at the University of Colorado School of Medicine.

Dr. Greisman is former President of the Colorado Chapter of the American College of Emergency Physicians and is Chairman of the Emergency Medical Care Physician Advisors Committee of the Colorado Medical Society. He is a member of the Arapahoe Medical Society and served as its Delegate to the Colorado Medical Society from 1979 to 1981.

Dr. Greisman received the D. O. degree from the College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1973. He served his internship at Memorial Osteopathic Hospital, York, Pennsylvania, and his residency at Denver General Hospital and St. Anthony Hospital Systems.

K. Mason Howard, M.D., Chairman and Chief Executive Officer of Copic, noted that Dr. Greisman adds professional breadth and stature to the board.



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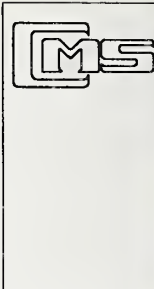
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March, 1992

Volume 89, Number 3

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## The Impact on YOUR Office

see page 76

### Also In This Issue:

Practice Parameters, Insurance Companies and the Government

p. 73

by Harrison G. Butler, III, MD

Doctors Day • 1992—Honoring YOU

p. 85

The Bag Lady: Not What You Think

p. 88

by Suzie Hutchison, MSII, University of Colorado School of Medicine

Americans With Disabilities Act—It Affects Your Practice

p. 78

Physician Professional Marketing: How Ethical Is It?

p. 93

Colorado Gyn/Ob Society

p. 99

Mile High News from the CMS Auxiliary

p. 95





# Goals Vs. Performance



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# CMS Med Fax®

**AT PRESS TIME...**

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

CMS Med Fax®

*by Montgomery Little Young Campbell and McGrew, P.C.*

legal counsel to the Colorado Medical Society

## AIDS Debate Continues

As Colorado Medicine was going to press, an article appeared in the Rocky Mountain News, headed "Doctors to debate AIDS policy."

Since this article included elements from a variety of physician concerns, Colorado Medicine feels it important to clarify some of those elements and their relation to CMS policy.

The article referred to "the proposed policy, up for debate" at the Interim Meeting of the House of Delegates.

- 1) This "proposed policy" deals entirely with confidentiality of the HIV status of CMS member physicians and is not related to the testing of physicians for HIV.
- 2) This "proposed policy" is separate and distinct from the current CMS policy which deals with HIV and AIDS testing of physicians. The proposed resolution was not submitted by the CMS AIDS Task Force, and in no way impinges upon the CMS AIDS policy as set forth by the AIDS Task Force prior to the 1991 CMS Annual Meeting of the House of Delegates.
- 3) In discussing this matter, the writer stated the proposal "calls on doctors to watch what they say to the media and public." Colorado Medical Society is in no way attempting to be secretive in its ongoing deliberations over HIV testing or matters of confidentiality. The article included comments of those who authored the proposed resolution cautioning physicians to not express personal beliefs or

opinions which could be mistakenly construed as policy of the Colorado Medical Society.

- 4) The article also stated that CMS is currently compiling results of a survey of doctors, with the survey "expected to carry considerable weight" in the debate of the policy at the Interim Meeting. Colorado Medical Society has conducted a member survey concerning the members' position on voluntary HIV testing; however, this survey is not related to the proposed resolution (which would protect the confidentiality of HIV status of CMS members).
- 5) The article included a statement which indicated the proposed policy would "put the organization somewhat at odds with its own insurance company, Copic." The present Copic discussion centers on issuing a professional liability policy exclusion that states if the policyholder becomes HIV positive and then knowingly transmits AIDS to a patient who sues the doctor, the doctor would lose any Copic malpractice insurance coverage. Presently being considered by Copic is that with this exclusion in the policy, the insured physician is also given an HIV disability compensation package to provide for the doctor when income from patient service ceases.

Copic and CMS are not "at odds" over this position. Copic also opposes "mandatory" testing, and is attempting to help the physician bridge that period of indecision, making it possible for the physician to consider the future of his practice by providing some measure of financial support during a time of transition.

## CMS Promotes Tobacco Free Schools

The Colorado Medical Society has supported its goal of a Tobacco Free Society by the year 2000 in part by contributing \$1,000 to Colorado Tobacco-Free Schools and Communities (CTFSC). This grant, part of a trust, is intended to

help CTFSC promote more tobacco free schools in the state. Check these listings to find out how your district stacks up. Then contact your local school officials and urge them to maintain a tobacco free environment in the interest of student health.

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Boulder Valley RE 2	Durango 9 R	Lewis Palmer 38	Plainview RE-2	Strasburg 31J
Brighton 27J	Eagle Co RE 50	Littleton 6	Platte Canyon 1	Stratton R 4
Byers 32J	East Grand 2	McClave RE2	Poudre R 1	Summit RE 1
Calhan R J-1	Elbert 200	Mesa Co. Valley 51	Pueblo City 60	Swink 93
Campo RE 6	Falcon 49	Moffat 2	Pueblo Rural Co. 70	Telluride R 1
Center 26 J	Fort Morgan RE-3	Mon. Cortez RE 1	Rangely RE 4	Trinidad 1
Cheraw 31	Fountain 8	Monte Vista C 8	Ridgway R 2	Valley RE 1
Cherry Creek 5	Garfield RE 2	Montrose Co. RE 1J	Roaring Fork RE-1	West Grand 1J
Cheyenne Co RE 5	Gunnison Watersd RE 1J	Mountain Valley Re-1	Rocky Ford R 2	Westminster 50
Cheyenne Mt. 12	Haxton RE2J	North Conejos RE 1J	Sanford C J	Wiley RE 13-JT
Clear Creek RE 1	Hoshone Reorg 3	Northglenn-Thornton 12	Sangre DeCristo RE22J	Woodland Park RE-2
Colorado Springs 11	Huerfano RE 1	Norwood R 2J	Sargent RE 33J	Woodlin R 104
Consolidated C-1	Jefferson Co. R-1	Otis R3	Sheridan	

## 97 Districts NOT Tobacco Free (55%)

18 Districts which allow smoking in buildings by staff:

Aguilar RE-6	Cañon City RE-1	Fort Lupton RE-8	Plateau RE-5
Alamosa RE11J	Centennial R-1	Johnstown Milliken RE-5J	South Conejos 10
Bayfield 10JT	Cripple Crk-Victor RE-1	Kiowa C-2	Weldon Valley RE20J
Brush RE-2J	Crowley Co. RE-1J	Mancos RE-6	Wiggins RE-50-J
Cañon City RE-1	Dolores Co. RE No. 2	Moffat Co. RE No. 1	

19 Districts which allow smoking on grounds by students:

Academy 20	Denver Co. 1	Greeley 6	Springfield RE-4
Adams County 14	Elizabeth C-1	Julesburg RE-1	St. Vrain Valley RE-1J
Adams-Arapahoe 28-J	Englewood 1	Las Animas RE-1	West Yuma Co. RJ-1
Akron R-1	Florence RE-2	Manitou Springs 14	Windsfield 3
Ariba-Flagler C-20	Fort Lupton RE-8	Salida RE-32	

87 Districts which allow smoking on grounds by staff:

Academy 20	Cotopaxi RE-3	Frenchman RE-3	Kiowa C-2	Prarie RE-11
Adams-Arapahoe 28J	Creede Consol 1	Garfield 16	Kit Carson R-1	Primero Reorg 2
Aguilar RE-6	Crowley Co. FE-1J	Genoa-Hugo C-11-3	Las Animas RE-1	Pritchett RE-3
Alamosa RE11J	Deer Trail 26J	Gilpin Co. RE-1	Limon RE-4J	Salida R-32
Arickaree R-2	Delta Co. 50(J)	Granada RE-1	Lone Star 101\	Sierra Grande R-30
Ariba-Flagler C-20	Denver Co. 1	Hanover 28	Mancos RE-6	South Conejos 10
Ault-Highland RE-9	Dolores RE-4A	Harrison 2	Manitou Spgs. 14	Springfield RE-4
Bennett 29J	Eads RE-1	Hayden RE-1	Manzanola 3-J	St. Vrain Valley RE-1J
Bethune R-5	East Otero R-1	Hi Plains R-23	Mapleton 1	Thompson R-2J
Big Sandy 100 J	East Yuma Co. RJ-2	Hinsdale RE-1	Meeker RE-1	Vilas RE-5
Branson RE-82	Eaton RE-2	Holly RE-3	Miami/Yoder 60-JT	Walsh RE-1
Briggsdale RE-10	Edison 54 JT	Holyoke RE-1J	North Park R-1	Weld RE-1
Buena Vista R-31	Elizabeth C-1	Ignacio 11-JT	Park Co. RE-2	Weld RE-3
Buffalo RE-4J	Ellicott 22	Johnstown-Milliken RE-5J	Pawnee RE-12	West End Re-2
Burlington RE-6J	Englewood 1	Julesburg RE-1	Plateau Valley #50	West Yuma RJ-1
Cañon City RE-1	Florence RE-2	Karval RE-23	Platte Valley RE-3	Widfield 3
Centennial R-1	Fowler R-4J	Kim RE-88	Platte Valley RE-7	Wiggins RE-50-J
				Windsor RE-4

For more information:  
Connie Acott,  
Tobacco Free  
Schools and Communities, Colorado  
State University  
Cooperative Extension, State 4-H  
Office, Aylesworth  
Hall, #125, Fort  
Collins, CO 80523  
(303) 491-6421





# Colorado Medicine

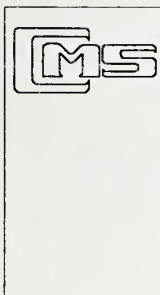
March, 1992

Volume 89, Number 3



## Cover Story

The new HIV-related OSHA workplace regulations in the healthcare field must be looked at carefully. They're no child's game, and the force of the rules could shake the very foundation of your practice. See pg. 76



## Departments

- 73 President's Letter
- 81 The Lobby
- 86 Health Department
- 94 Board of Directors
- 99 Specialties
- 101 Classified Advertising

## In This Issue...

- 73 Practice Parameters, Insurance Companies and the Government  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 76 OSHA Workplace Requirements—They Affect YOU
- 78 Americans with Disabilities Act—Do you comply?
- 80 A Survey—Let's Find Out What You Think  
*Frederick A. Lewis, Jr., M.D.*
- 85 Doctors Day • 1992
- 88 The Bag Lady—A Visit to the Streets  
*Suzie Hutchison, MSII*  
*University of Colorado School of Medicine*
- 91 Would You Do It, Doctor?—The Kevorkian Question  
*by Thomas H. Coleman, MD*
- 93 Professional Marketing—How Ethical Is It?  
*George E. Burdick, MD*
- 95 MILE HIGH NEWS—from the Colorado Medical Society Auxiliary

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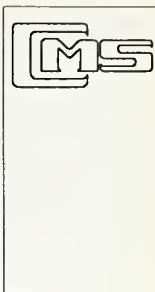
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Harrison G. Butler, III, MD  
President, 1991-1992

## Practice Parameters, Insurance Companies and the Government

### Physicians Harassed

Last Tuesday Sandi Maloney, Edie Register and I attended a meeting at the Clear Creek County Medical Society Offices. The purpose of the meeting was to explore the possibility of seeking legislative relief from the capricious acts and harassment of many (not all) insurance companies and health maintenance organizations (HMO's). We were each able to cite numerous incidents of abuse of physicians and patients.

Many HMO's and insurance companies routinely delay reimbursement, down code claims and deny reimbursement if the claim does not fit their "practice parameters." I have attempted to get a list of their parameters, but have been rebuked, ostensibly because of proprietary considerations.

Medicare is world class at this game. With the new coding regulations, they are armed with a complicated system that will be used effectively to deny reimbursement to physicians. If the past is any teacher, Medicare will use the "system" to gain access to physician offices on a scale heretofore unprecedented. This will reduce payment for services and increase the administrative costs from 30+% to God knows what.

### "High Fives" at HCFA

However, this is a minor irritation compared to the holocaust that is looming. I wondered why there was cheering and high fives at HCFA and in the mahogany and leather boardrooms of insurance corporations when our AMA House of Delegates endorsed the development of practice parameters. It took a while for me to comprehend (I'm a surgeon) what this meant to the regulators. I now understand that "parameters" are a bonanza of regulatory clout.

Don't preach to me about the "good points" of standardizing medicine into an algorithm. Hitler had his "good points." He was a great organizer and I suppose he would have loved practice parameters. Why? Because it would be easy to find the docs who deviated and to "correct" deviant behavior. Sure, these regulatory rules will start out somewhat flexible, but the self proclaimed experts will gradually tighten the rules until there will be little flexibility to account for differences in patients, diseases and concomitant pathologic processes.

*"Don't preach to me about the 'good points' of standardizing medicine into an algorithm. Hitler had his 'good points.' He was a great organizer and I suppose he would have loved practice parameters."*

*continues on following page...*

*"I think we're ready to do whatever it takes...to stop this unnecessary intrusion into the physician-patient relationship."*

*Harrison G. Butler, III, MD*

## Working Through the "Process"

Let's think about what happens now when there is a perceived divergence from the rules. First, there is the obligatory completion of endless forms, copying of pages and pages of records, physician letters of appeal and numerous long distance phone calls during which you are placed on terminal hold.

Next there are the "hate" letters from HCFA and the insurance companies to the patient, accusing the physician of over charging, gouging and abuse. I recently heard of one company who volunteered to find the patient a lawyer to fight this "over-charge."

Then our Peer Review Organizations and the Board of Medical Examiners can become involved to sanction and punish these doctor deviates...and so it goes. Practice parameters will make this much worse.

## What's the Answer?

If this sounds angry, it is! I'm mad as hell! The Colorado Medical Society membership is also angry, judging from your comments. I think we're ready to

do whatever it takes, including legislation, to stop this unnecessary intrusion into the physician-patient relationship. The Council on Medical Service of the CMS will be looking at practice parameters in detail, and considering alternatives such as competency testing (which I feel would enable us to remain flexible and treat patients with care and judgment). I've charged the Council with having a statement for us by the Annual Meeting at the latest.

The Council on Legislation will be looking at what will be necessary for legislation next year. I might add that James Todd, MD, Executive Vice President of the American Medical Association, will be present at the CMS Interim Meeting, March 6th and 7th. This should provide us with an opportunity to talk with the AMA staff about this and other problems.

As always, I look forward to your letters and comments. Thank you for the tremendous return on the HIV survey. I'm proud of the physicians in Colorado! Also, come to the Interim Meeting in March. We will be considering some of the most important issues to impact medicine this century and we need your input.



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# Certified Correctional Health Professionals

The National Commission on Correctional Health Care (NCCHC) announced recently that the number certified under the Certified Correctional Health Professional (CCHP) program has reached 500 nationwide. CCHP acknowledges the special skills needed to provide health care in a correctional institution.

Several workers in Colorado's jails have received their CCHP certification,

which must be maintained by continuing participation in professional education. The Colorado Jail Health Care Project, administered by the Colorado Medical Society, cooperates with NCCHC in both jail accreditation and in promoting CCHP status among Colorado's health professionals who work in corrections. For more information, contact Jail Project Coordinator Ellen Stein at (303) 779-5455.

*"CCHP is the first such process that demonstrates professionalism and excellence in correctional health care."*

*R. Scott Chavez, PA-C  
Vice President, Professional Services  
National Commission on Correctional Health Care*

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\*Registration fee is waived for Swedish Medical Center physicians, nurses and ancillary personnel.



# OSHA Workplace Requirements In Effect:

*The provisions of this standard will be enforced by OSHA and compliance assured via unannounced inspections.*

## **OSHA announces final rule re: Occupational Exposure to Bloodborne Pathogens**

OSHA published its final rule on Occupational Exposure to Bloodborne Pathogens in December, 1991. The rule promulgates a standard to eliminate or minimize occupational exposure to Hepatitis B Virus, Human Immunodeficiency Virus and other bloodborne pathogens. The standard applies to all occupational exposures to blood or other potentially infectious materials and affects all employers of employees who, in the course of performing their job related duties, might reasonably anticipate skin, eye, mucous membrane, or parenteral contact with such infectious materials. The standard goes into effect March 6, 1992, and requires that portions of the standard be implemented beginning May, 1992.

The standard is a modification of the OSHA recommendations which were published in 1988. It is still based on the utilization of the Centers for Disease Control's Universal Precautions and it contains many of the same components as the earlier recommendations. The key provisions are as follows:

**1) Exposure Control Plan:** Each employer having an employee(s) for whom exposure to blood or other potentially infectious materials might reasonably be expected in the course of performing their job related duties, shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure. Such a plan must include exposure determination (OSHA-designed job classifications based on potential for exposure)

and the use of universal precautions. The Exposure Control Plan must be in place on or before **May 5, 1992.**

**2) Engineering and Work Practice Controls:** These shall be used to eliminate or minimize employee exposure. These controls include proper hand washing requirements, appropriate handling of needles and sharps and the availability of personal protective equipment. Provisions in this section must be implemented by **July 6, 1992.**

**3) Personal Protective Equipment:** An employer shall provide, at no cost to the employee, appropriate personal protective equipment. Provisions under this section of the standard include proper use; accessibility; cleaning, laundering, and disposal; repair and replacement; and types of equipment. Provisions in this section must be implemented by **July 6, 1992.**

**4) Housekeeping:** Employers shall ensure that the worksite is maintained in a clean and sanitary condition and shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area. This section includes provisions for proper decontamination, handling of regulated waste, containers for needles and other sharps, and laundry. These provisions must be implemented by **July 6, 1992.**

**5) Training Requirements:** These include provision of the hepatitis B vaccine and vaccination series to all employees with the potential for occupational exposure, post-exposure medical evaluation and follow-up for



# Direct Impact on Physician Offices

those who have had an exposure incident, and information to be provided to the health care professional also providing care to the employee, as well as communication of hazards to employees in the form of labels, signs, and information and training which must be provided during work hours and at no cost to all employees potentially at risk for occupational exposures. Initial information and training requirements must be provided to your employees on or before June 4, 1992 and additional provisions, including the availability of Hepatitis B vaccine, must be implemented by **July 6, 1992**.

**6) Recordkeeping:** Accurate records must be kept for all employees potentially at risk for occupational exposure. Such records are to include medical (dates of vaccinations, results of follow-up procedures, etc.) as well as training information. These provisions take effect **June 4, 1992**.

The provisions of this standard will be enforced by OSHA and compliance assured via unannounced inspections. Every facility is required to have available a copy of the OSHA Standard. Colorado Medical Society will be publishing a complete copy of this standard in the April issue of *Colorado Medicine*.

**For further information, the following resources are available:**

- U.S. Department of Labor—OSHA Region VIII Office  
1961 Stout Street, Room 1576  
Denver, CO 80294  
(303) 844-3061
- Washington Office—Health Standards  
(202) 523-7157

Additional resources which have come to the attention of CMS:

- A comprehensive training program, "For Your Protection: The OSHA Regulations on Bloodborne Pathogens," is available for sale from the AMA, containing a 25-minute training videotape, an Administrator's guide, model exposure control plan and training manuals. The program covers the relevant portions of the OSHA regulations for the purpose of training employees. Call: 1-800-933-4AMT
- Advanced Medical Concepts International, 7125 Shady Oak Road, Eden Prairie, MN 55344, 1-800-373-2624, has produced educational and training programs. OSHA Compliance/Infection Control seminars are available. In addition, AMCI publishes an OSHA compliance program, which includes 1) "Your Right To Know," including employer and employee manuals and overview videos providing training on blood borne diseases and tools for programs to minimize occupational exposure, and 2) *Document Master OSHA Forms*, an office manual containing forms and documents necessary for compliance with OSHA standards, including the standard on bloodborne pathogens.
- Current Concepts Seminars, Inc. 5700 Stirling Road, Hollywood, FL 33021, 1-800-969-1009, has prepared an infection control plan and employee training manual and provides employee training.

*Accurate records must be kept for all employees potentially at risk for occupational exposure*

# Americans With Disabilities Act:

## may require changes for your practice

by Howard Larkin  
AMN Staff

Reprinted from American Medical News, January 27, 1992

*"A lot of people think it will engender a lot of litigation."*

Doctors have a new federal law to deal with: the Americans with Disabilities Act.

The law, with an effective date for some provisions of January 26, may require you or your landlord to spend money for building modifications and could require changes in office procedures to accommodate disabled patients and workers. When and how much the law will affect you depends in part on the size of your practice.

The statute requires medical practices of all sizes to make "reasonable accommodations" allowing disabled patients equal access to facilities and services. Those accommodations could range from building ramps and handrails for wheelchair-bound patients to providing sign language interpreters for hearing-impaired patients.

Many businesses were required to comply by January 26. Exceptions are those with 25 or fewer employees and annual gross receipts of \$1 million or less, which have until July 26. Those with 10 or fewer employees and annual gross receipts of \$500,000 or less have until January 26, 1993.

Practices employing 15 or more workers also will be prohibited from discriminating against disabled candidates in hiring. The act calls for "reasonable accommodation" which could include buying special equipment or changing work procedures to allow disabled employees to work.

The employment provisions take effect July 26 for businesses with 25 or more employees. Businesses with 15 to 24 employees have until July 26, 1994, to comply.

But it's not a good idea to wait until the last minute to think about comply-

ing — especially since it could require construction or purchase of special equipment, said Lee Johnson, an attorney for Medical Liability Mutual Insurance Co., a New York-based physician-owned liability carrier insuring about 14,000 doctors. Violators may be sued for actual damages as well as compensatory punitive damages and may be fined up to \$50,000 for a first offense and \$100,000 for a second offense.

Johnson recommends consulting with an attorney and other professionals, such as architects or interior designers, who are well versed in the statute's requirements. As in many sweeping federal laws, the definitions of terms such as "reasonable accommodations" and even of what constitutes a disability are vague, leaving broad latitude for interpretation and unanswered questions about just what must be done to comply.

"The whole thing is really fuzzy," said Harry Sangerman, a partner in the Chicago office of attorneys McDermott, Will & Emery. "A lot of people think it will engender a lot of litigation."

What's reasonable in a given situation will depend on the facts, Sangerman said. If, for example, a doctor expects that he or she may have hearing or vision-impaired patients, it may be considered reasonable to provide interpreters or consent forms in braille. But if a doctor has no such patients and isn't likely to get them, such accommodations might be unnecessary.

Finances also will play a part in what is considered reasonable, Sangerman said. A larger, richer practice most likely will be held to stricter standards than will smaller, less well-



financed operations.

Most medical offices will require some physical changes, said Cynthia Leibrock, president of Denver-based *Easy Access Barrier Free Design*. Leibrock, an interior designer, has conducted a number of compliance surveys for hospitals, clinics and medical office buildings.

What's reasonable in changing architectural features of existing structures will depend in part on what's "readily achievable," Johnson said. "Would you have to move filing cabinets out of the way to allow a wheelchair through? Yes. Would you have to knock down

walls if the corridors are too narrow? That's not so clear."

The statute and regulations enforcing it are much clearer on standards for new construction, Johnson said. Costs for complying with the new construction standards, which must be met by any project begun after January 26 are minimal, usually less than 1% of total costs, Leibrock said.

Practices that must comply with the statute's employment provisions cannot refuse to hire a qualified candidate simply because he or she has a disability. They also will be barred from discriminating in hiring against

candidates who can do the job with reasonable accommodations, Sangerman said. That could mean that special equipment must be purchased or work spaces and procedures altered for a disabled employee.

For example, a hearing-impaired nurse might be accommodated by purchasing a digital read-out blood pressure cuff or by having a nursing assistant or other employee take blood pressure, Sangerman said.

Information on the statute is available from the Justice Department, which will enforce the public accommodation provisions, and the Equal Employment Opportunity Commission, which will enforce the employment provisions. Call the Justice Dept. at (202) 514-0301 and the EEOC at (800) 669-3362. The Washington-D.C.-based Architectural and Transportation Barriers Compliance Board, a not-for-profit group, also publishes compliance guidelines for public accommodations.

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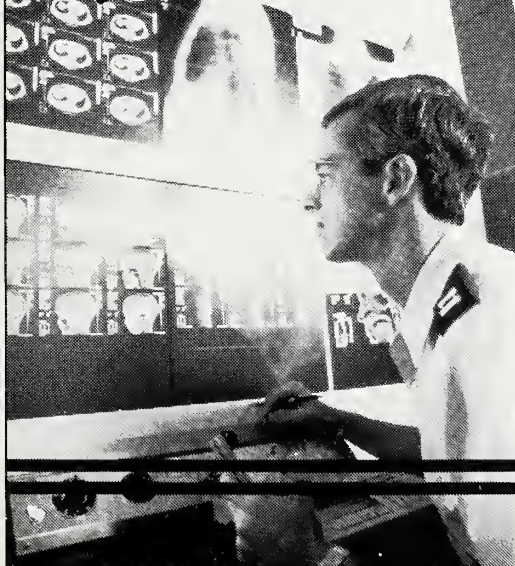
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## A Survey

Harrison G. Butler, III, M.D.  
President, Colorado Medical Society

Dear Corky:

I am responding to the invitation issued in the last paragraph of your article on health care policy in the February issue of *Colorado Medicine*.

At another meeting last week, I listened to Rod Brewster (Assistant Executive Director, Colorado Medical Society) report on the excellent return which the CMS had received from its questionnaire about AIDS, and it occurred to me that it would be useful to sample physician opinion about the future of the health care delivery system and what changes, if any, they feel should be made. I think I detect an understandable difference in opinion in CMS leadership as to which health care proposal we should actively support. Others may say that the general physician is too ill informed on the issues to offer an opinion, but I suspect that they know at least as much as the individuals who will ultimately make the decisions, namely the politicians in Congress.

I would suggest a questionnaire which lays out the alternatives in an oversimplified but clear fashion and ask physicians to vote for their favorite, their top three, list their choices in order, or whatever. It would certainly give us information about the views of our constituents which, to my knowledge, we do not possess at the present time. I would conceptualize the

alternatives somewhat as follows:

In terms of the current debate on the future structure of the health care delivery system, the Colorado Medical Society should:

1. Do nothing, be politically inactive, and allow politicians and society to determine what changes need to be made, if any.
2. The CMS should actively lobby for and support:
  - a. The status quo - actively resist any and all change.
  - b. Bush approach - "Tinkering" with the status quo - increase in competition, managed care, tax credits, vouchers, etc.
  - c. Oregon approach - "Rationing" of health care - criteria for rationing to be determined by society.
  - d. "Pay or Play" - Mandate employer coverage of all employees with basic minimum benefits or employers would have to contribute to a pool which would then be used to buy insurance for all of the uninsured.
  - e. Single payer system - physicians and hospitals operate independently but contract with and are paid by the government - both state and federal - Canadian system - also similar to UHICO approach in current proposed Colorado legislation.
  - f. Modification of single payer system in which all money goes to the state or federal government which, in turn, contracts with a specified number of insurance plans who then compete with each other. Physicians and hospitals ally themselves with

an insurance plan. Colorado Care - similar bills at the national level.

- g. True nationalized health system with physicians and hospitals working directly for the government - England.

- h. Emphasis on wellness, acupuncture, and chiropractor - Jerry Brown (as described in the New York Times).

*NOTE: Proposals d. through g. also generally provide for the elimination of Medicare and Medicaid.*

There may be others which should be added to the list, but I would suggest that the description be kept general and brief since the details can and will be worked out in a tedious political fashion as the legislation is drafted and debated.

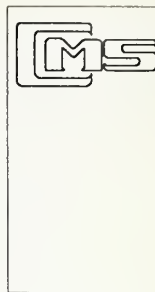
Personally, I feel strongly that "c" is the only ultimate rational solution and would suggest that we stop temporizing and go there directly. However, that is obviously just my opinion and I would be interested in learning the opinion of others.

If you feel that this suggestion has merit and if I can be of any help during your term of office, please let me know.

Sincerely yours,  
Frederick A. Lewis, Jr., M.D.

*Editor's Note: If you are of a mind, why not save all the expense and trouble of another survey — circle your choice on Dr. Lewis' proposed survey questions above, tear it out and send it or FAX it, (303) 771-8657 to CMS. Please include your name and practice location.*





Alan D. Rapp, MD, Chairman  
CMS Council on Legislation  
with  
Sue Ellen Quam, Director  
Department of Government Relations  
and  
Lorraine Koehn  
Program Manager/Lobbyist

## Abortion

SB 169, CONCERNING A REQUIREMENT THAT RELEVANT INFORMATION BE PROVIDED TO A WOMAN PRIOR TO THE WOMAN'S CHOICE WHETHER TO HAVE AN ABORTION (Roberts): Requires that specific information in a packet prepared by the Dept. of Health be provided to a woman seeking an abortion. Prohibits the performing of an abortion before a specified time period after which a woman has been provided with an information packet. Requires that a woman affirm in writing that she received the information packet before the abortion is to be performed.

Describes a physician's duties in regard to a woman's informed choice. Requires the Dept. of Health to prepare packets of information for women seeking abortions in the state.

Bill Status: Killed in HEWI Committee on 2/7

COL Position: Bill heard prior to COL consideration

## Emergency Medicine

HB 1081, CONCERNING PERSONS WHO PROVIDE EMERGENCY MEDICAL SERVICES (Jerke): Eliminates the requirement of a physician advisor for emergency medical technicians. Exempts physician advisors to emergency medical technicians or an emergency medical services organization from civil liability for acts or omissions arising from the advisor's supervision or direction. Exempts emergency medical technicians who render emergency care from liability for civil damages arising from acts or omissions rendered in good faith.

Bill Status: Postponed Indefinitely in HEWI Committee

COL Position: Oppose

SB 78, PROVISION OF LOCAL EMERGENCY MEDICAL SERVICES (Traylor): Increases the amount in the emergency medical services account of the highway users tax fund allocated for the training of emergency medical service personnel, and specifies that a certain percentage shall be allocated for the Rocky Mountain poison center. Provides that moneys appropriated to counties for planning should be used to coordinate emergency medical services in the county and between counties when possible.

Bill Status: Passed the Senate minus funding of the Poison Control Center .

CMS Position: Support

## Health Access

SB 4, CONCERNING A STUDY OF A COLORADO CARE PROGRAM TO PROVIDE HEALTH INSURANCE COVERAGE FOR ALL COLORADO RESIDENTS (Hopper):

Requires the Dept. of Regulatory Agencies to study the feasibility and the cost savings associated with implementing a statewide health care program to be known as the "Colorado Care Program." Requires the department, to conduct a demonstration project under which counties may develop and implement a county wide health care program for citizens within their respective counties to test some or all of the features of the Colorado Care Program.

Bill Status: Passed HEWI Committee; awaiting 2nd reading

CMS Position: Monitor

SB 66, Concerning a Study of a Universal Health Insurance Plan to Provide Health Care Coverage for All Colorado Residents (Mares): Requires the executive directors of the dept. of health and of the state dept of social services and the commissioner of

*It has already been a busy legislative session. Here is a summary of some of the bills taken up so far by your Colorado representatives, along with notations of the positions taken by CMS on these issues.*



insurance to jointly conduct a study of the feasibility & the cost savings associated with implementing universal health insurance for the state. Authorizes the dept. of regulatory agencies to assist counties in implementing demonstration projects under which counties may develop and implement a county wide health care program for citizens within their respective counties to test some or all of the features of a universal health insurance plan. Bill Status: Amended, passed Business Affairs & Labor; awaiting 2nd reading COL Position: Monitor

HB 1052, CONCERNING THE DEFINITION OF BASIC HEALTH CARE (Irwin): Creates a health services commission which is directed to conduct public hearings on public health issues and a community value analysis of public opinion on health care resource allocation. Directs the commission to prepare a definition of basic health care for the citizens of this state. Requires the commission to report to the general assembly and to the governor on its findings and recommendations for implementing a health care system based on the definition of basic health care. Bill Status: Amended, passed HEWI Committee; awaiting 2nd reading. COL Position: Monitor but will support if long term care is added.

## Health & Safety

SB 49, Elimination of the Requirement That There Be An Alleged Violation of the Uniform Motor Vehicle Law Other Than A Safety Belt Violation Before a Law Enforcement Officer May Stop a Driver for Violation of the Safety Belt Law (Hopper): Eliminates the requirement that citations for safety belt violations be issued only to drivers who have been

stopped for an alleged violation of the Uniform Motor Vehicle Law other than the safety belt law.

Bill Status: Killed on 3rd reading in Senate

CMS Position: Support

HB 1182, BREAST CANCER SCREENING (Tucker): Authorizes expenditures for the operation of the Colorado mammography advocacy project's computerized tracking and follow-up system for breast cancer screening and early detection. Permanently extends the breast cancer screening program which was scheduled for repeal on July 1, 1992.

Bill Status: Passed HEWI; referred to Appropriations

CMS Position: Support

## Insurance

SB 42, REVISIONS TO THE "COLORADO UNINSURABLE HEALTH INSURANCE PLAN ACT" (Traylor): Makes it an unfair method of competition to arrange for an employee to apply to the plan for the purpose of separating from group health coverage. Eliminates the board's ability to develop a list of medical or health conditions the presence of which would exempt a person from having to apply to another health insurance carrier before being eligible for a policy under the plan. Includes many "housekeeping" provisions.

Bill Status: Passed Senate; referred to House Business Affairs

COL Position: Council on Physician/Patient Advocacy recommends "Support"

SB 179, CONCERNING MEDICAL BENEFITS (Mendez): Amends medical insurance provisions, including those relating to health maintenance organizations, to require that a mini-

mum benefit be provided to all enrollees with respect to mammography screening, and that such benefit may not be reduced by the application of a deductible. Requires that medical insurance policies issued out-of-state that cover Colorado residents provide a minimum mammography benefit, or such policy will be subject to all Colorado insurance regulations. Bill Status: Assigned to Business Affairs & Labor COL Position: Physician Patient Advocacy and Medical Service Councils recommend "Support"

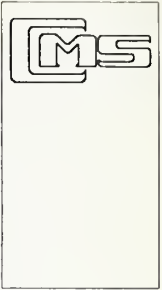
## Maternal & Child Health

SB 177, CIRCUMSTANCES FOR PROVIDING MEDICAL INTERVENTIONS IN CHILD ABUSE OR NEGLECT PROCEEDINGS (Wham): Authorizes the court to order medical evaluations in child abuse or neglect proceedings, including cases involving spiritual healing. Removes the presumption regarding recognized methods of religious healing. Bill Status: Passed Judiciary Committee; awaiting 2nd reading CMS Position: Support in Accordance with House of Delegates Resolution

## Medicaid Issues

SB 65, REFORM OF METHODS FOR PROVIDING MEDICAL ASSISTANCE TO INDIGENT PERSONS IN COLORADO (Bird): Specifies that the general assembly must act through legislation to enact a new method for providing health care to poor persons in the state. Describes possible options for providing health care to the indigent population. Requires the general assembly to solicit grants or donations from public or private sources to fund the development of an alternative medical assistance





program.  
 Bill Status: Amended, passed; HEWI Committee  
 COL Position: Referred to Physician/Patient Advocacy

HB 1306, DELIVERY OF SERVICES PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT" THROUGH MANAGED CARE (Coffman): Requires the Dept. of Social Services to promulgate rules and regulations which establish a managed care system. Requires the department to establish rules and regulations which provide that medical services which are compensable under both title XIX and Title XVIII of the "Social Security Act" shall be paid at the lower rate. Authorizes the department to enter into negotiated contracts with vendors to provide medical services based on a fixed rate of reimbursement per recipient.

Bill Status: Assigned to HEWI  
 COL Position: Council on Physician/Patient Advocacy recommends "Monitor"

HB 1311, REPEAL OF THE SINGLE ENTRY POINT SYSTEM FOR THE DELIVERY OF LONG-TERM CARE SERVICES (Dyer): Repeals the single entry point system for the delivery of long-term care services under Medicaid.  
 Bill Status: Assigned to HEWI  
 COL Position: Council on Physician/Patient Advocacy recommends "Oppose"

## Medical Records

HB 1319, PARENTAL ACCESS TO MEDICAL RECORDS RELATING TO MEDICAL TREATMENT OF A MINOR PATIENT FOR DRUG ABUSE (DeHerrera): Makes an exception to a statute which allows a minor to be treated for addiction to or

the use of drugs without parental notification or consent. Permits access to medical records to the parent or legal guardian in the circumstance in which the parent or legal guardian in conjunction with the minor patient requests or consents to treatment of the minor patient for addition or drug use.  
 Bill Status: Assigned to HEWI  
 COL Position: Referred to Council on Medical Service

## Medical Treatment

SB 3, CONCERNING PATIENT AUTONOMY IN REGARD TO THE MAKING OF MEDICAL TREATMENT DECISIONS (Wham): Authorizes persons to make advance medical treatment decisions for another person who becomes unconscious or incapacitated. Specifies the requirements for making a medical durable power of attorney and states what directives may be incorporated in a medical durable power of attorney, including the appointment of a health care agent to act on behalf of the person who executes the medical durable power of attorney. Allows for the designation of a health care proxy to act on an incapacitated patient's behalf when the patient has not executed a medical durable power of attorney and has no appointed health care agent or court-appointed guardian to act on the patient's behalf. Provides for the execution of a cardiopulmonary resuscitation declaration (CPR declaration). Allows the Dept. of Health to impose a fee for forms and wrist bracelets issued pursuant to the act.  
 Bill Status: Assigned to the Judiciary Committee  
 COL Position: Oppose but support concept and request simplification (see minutes of 1/16/92 if further information is desired)

## Professions

SB 96, PROFESSIONAL NURSES' POWER TO DELEGATE NURSING FUNCTIONS (Wham): Provides that professional nurses shall have the authority, when engaging in the practice of professional nursing, to delegate to others the provision of therapy and treatment. Provides that the nurse shall be solely responsible for determining the degree of supervision required.

Bill Status: Passed HEWI with amendments; awaiting 2nd reading  
 COL Position: Council on Legislation recommends monitor with CMS and COPIC amendments.

HB 1010, CONCERNING THE PRACTICE OF MIDWIFERY, AND IN CONNECTION THEREWITH, PROVIDING FOR THE REGISTRATION OF MIDWIVES WITHIN THE DIVISION OF REGISTRATIONS (Owens): Decriminalizes the unlicensed practice of midwifery, by excluding it from the definition of the practice of medicine, while expressly not immunizing midwives from other civil or criminal liability. Requires registration of direct-entry ("lay") midwives with the division of registrations in the dept. of regulatory agencies.

Bill Status: Passed Judiciary Committee; awaiting 2nd reading  
 CMS Position: Oppose

HB 1030, REGULATION OF THE PRACTICE OF OPTOMETRY AND CONTINUING THE BOARD OF OPTOMETRIC EXAMINERS ((Fleming): Will allow optometrists to treat the eye or its appendages. The bill was approved by the Sunrise/Sunset Committee this past summer and does not allow optometrists to treat iritis and glaucoma as was proposed in the sunrise/sunset application. CMS testified against this treatment.



## **Jerke, Rizzuto Sponsor Rural Health Initiative**

*In an earlier article in Colorado Medicine, we failed to give proper credit to Colorado Representative William Jerke of LaSalle and Senator James Rizzuto of La Junta for sponsoring House Bill 91-1274. This bill created the state loan repayment program for health care professionals practicing in communities with underserved health care needs.*

**Bill Status:** Assigned to the HEWI Committee

**CMS Position:** Monitor to assure that treatment of iritis & glaucoma are not amended into the bill.

**HB 1091, CONCERNING THE AUTHORITY OF PHYSICIAN ASSISTANTS (Chlouber):** Provides that a physician may delegate to a physician assistant the authority to implement any act under a medical plan, including initiating medical directives to professional and practical nurses, when the delegation is made pursuant to written protocol or the oral or written directions of the physician. Provides that a physician need not be on hospital premises to supervise the physician assistant when the delegated duties are being carried out.

**Bill Status:** Passed HEWI Committee with amendments;

**COL Position:** Monitor with the passage of the HEWI amendments.

**HB 1169, ARTIFICIAL TANNING DEVICES (Martin):** Creates the "Artificial Tanning Device Operation Act". Requires annual registration and inspection of artificial tanning devices made available for public use by the Dept. of Health.

**Bill Status:** Re-written and HEWI Committee referred to Appropriations  
**CMS Position:** Support

## **Taxes**

**HB 1239, INCREASE IN THE CIGARETTE TAX (Sullivan):** Increases the cigarette tax. Adjusts the percentage of the taxes distributed to counties and cities and the percentage of the vendor discount.

**Bill Status:** Passed Finance Committee; awaiting 2nd reading

**COL Position:** Support

**SB 71, Enactment of the "Colorado**

**Workers' Health & Disability Act (Roberts):** Provides that the "Workers' Compensation Act of Colorado" shall not apply to employers who offer and pay for sickness and accident or health insurance and life insurance, including disability insurance, for on and off the job injuries to employees. Authorizes employees accepting coverage for work-related injuries under the act to sue employers for ordinary negligence for work-related injuries for up to a certain amount of money inclusive of disability benefits paid under the act, but not inclusive of payments for medical expenses.

**Bill Status:** Amended, passed Business Affairs & Labor Committee  
**COL Position:** Workers' Comp Advisory Committee recommends that CMS oppose this legislation.

**HB 1057, AUTHORITY OF EMPLOYERS TO REQUIRE EMPLOYEES TO PAY PART OF THE COST OF WORKERS' COMPENSATION COVERAGE :** Repeals the provision of law making it unlawful for employers to require employees to pay all or any part of the cost of workers' compensation insurance. Authorizes employers to require employees to pay up to a certain amount of the cost of workers' compensation coverage required by law.

**Bill Status:** Assigned to Business Affairs & Labor

**COL Position:** Workers' Comp Advisory Committee recommends that CMS oppose this legislation.

## **Information**

Members of the Colorado Medical Society may receive copies of any of the bills by contacting the CMS Department of Government Relations at 1-800-654-5653 or 779-5455, Ext. 427.



# Doctors Day • 1992

## 150 Years of Victory Over Pain

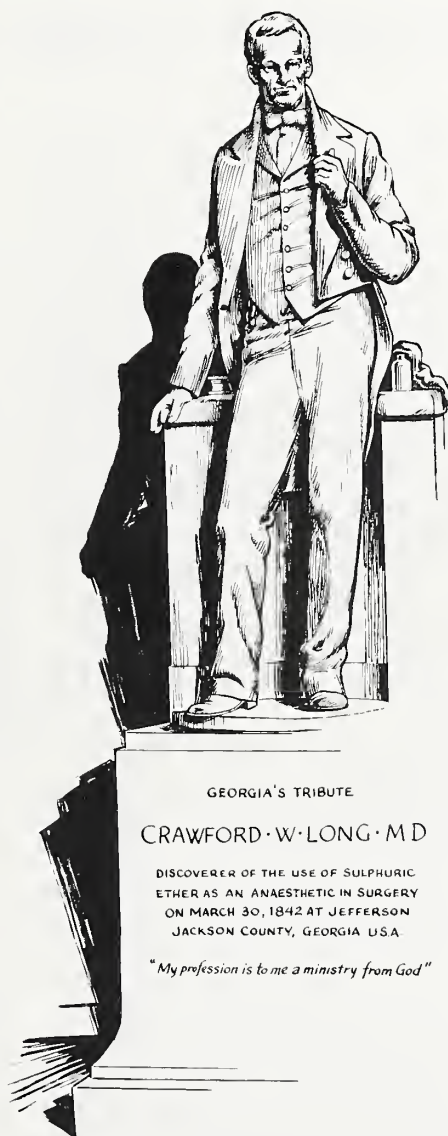
It's not the cold, scientific avenue for progress that one might have desired, but the path to modern surgical anesthesia has seen tremendous benefits to the patient. Fortunately, today there are no surgeons who remember the days of racing as fast as possible to complete the operation because the patient was in such unendurable pain. Stories of bungled amputations and lost fingers were abundant in those days.

In the 1800's, itinerant lecturers on chemistry entertained small town audiences with demonstrations of nitrous oxide. Audience participation led to expansion of the practice to parties in homes and schools, especially medical schools. One of those schools was the University of Pennsylvania, where Crawford W. Long was a medical student.

Later, when Dr. Long was practicing in rural Georgia, he received a request for some nitrous oxide for a party. Not having any, he remembered that sulfuric ether, then used for relief of byplay and renal colic, had similar consciousness altering effects.

Soon after, Dr. Long was examining two cysts on the neck of James M. Venable, who had delayed doing anything about them out of fear of the pain of the operation. Dr. Long remembered from his medical school days that those injured while under the influence of ether felt no pain at the time.

Mr. Venable agreed to an experiment, and on March 30, 1842, Dr. Long gave him ether on a towel to breathe. When he was unconscious, Dr. Long removed one of the cysts. Mr. Venable later swore he had felt nothing and did not realize the operation had been completed until he awoke. Thus, the era of modern anesthesia was born.



GEORGIA'S TRIBUTE

CRAWFORD W. LONG • M.D.

DISCOVERER OF THE USE OF SULPHURIC  
ETHER AS AN ANAESTHETIC IN SURGERY  
ON MARCH 30, 1842 AT JEFFERSON  
JACKSON COUNTY, GEORGIA U.S.A.

*"My profession is to me a ministry from God"*

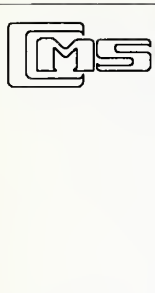
The Barrow County (Georgia) Auxiliary first celebrated Doctors Day on March 30, 1933 in honor of the dedication and achievements of Dr. Long and physicians like him. The Southern Medical Association took up the cause in 1935 and the U. S. Con-

gress officially established Doctors Day in 1958. Colorado Governor Roy Romer has also proclaimed March 30 as Doctors Day in Colorado.

### Thank You!

The Colorado Medical Society is pleased to join the Colorado Medical Society Auxiliary in honoring the following physicians on the occasion of Doctors Day, 1992. A contribution to the American Medical Association Education and Research Foundation has been made on behalf of each of these physicians by a spouse who serves on the CMSA Board of Directors.

Carter M. Ballinger, MD  
Gerald D. Brown, MD  
Bernard E. Campbell, MD  
John D. Glismann, MD  
Jerome R. Hanson, MD  
Jesse H. Humphries, MD  
William Inkret, Jr., MD  
Dale L. Kinzler, MD  
Muryl L. Laman, MD  
Thomas P. Larkin, MD  
Carl A. Lepisto, MD  
Kenneth R. Lovell, MD  
Frank D. Manart, MD  
Michael Michalek, MD  
Joseph S. Pollard, Jr., MD  
Jarvis D. Ryals, MD  
Theodore R. Sadler, Jr., MD  
Leroy J. Sides, MD  
Duane D. Sowl, MD  
Richard W. Talley, MD  
John A. Whitesel, MD



## Profile Report takes a look back

*by Amy Sage, Public Relations Director  
Colorado Department of Health*

*"Colorado citizens  
wanted some entity  
to be responsible."*

### **The World's Sanitarium**

In 1876, the year Colorado achieved statehood, the state had become known as "The World's Sanitarium," drawing victims of tuberculosis and asthma to the sunshine and clear air. By 1880, an estimated one third of the State's population had migrated to Colorado to seek improved health for themselves or their families. At one time, there were 17 tuberculosis hospitals in Colorado.

This information is included in a brief history of public health in a new Profile report on the Colorado Department of Health.

### **History of Public Health**

The report also says the Territorial Board of Health broke up in August 1876 when Colorado joined the union. Colorado's first General Assembly established the first State Board of Health in March, 1877 and charged it with the collection and study of vital statistics as a means of determining causes of illness and death, the control of epidemics and contagious disease and providing advice on proper sources of water supplies and places for sewage disposal.

The health board's first official vital statistics report on the 12 main causes of death (in 255 cases) in 1877 included consumption, diphtheria, scarlet fever, pneumonia, diseases of the heart, diarrheal diseases, typhoid fever, diseases of the kidney, infantile convulsions, peripheral diseases and

croup and congestion of the lungs. Seven causes of death were attributed to old age, for those between 70 and 97 years.

A few years later, all the board members resigned because the board had no real authority or budget. Fear of a nationwide epidemic in 1892 led to the appointment of another board of health since Colorado citizens wanted some entity to be responsible for quarantining persons suspected of carrying an infection. Two bills were passed in 1883 to create local boards of health and to create a state board of health with a budget and authority for punishing violators.

### **Expansion of the Department**

Public health programs added to the state health department were: plumbing inspection in 1917; reporting of venereal disease in 1918; public health nursing, established in 1922, was enlarged to child hygiene and public health nursing in 1925; sanitary engineering and administration in 1925.

Dr. Roy L. Cleere became the first executive officer of the State Division of Public Health in March, 1935, with its 14 employees and a \$40,000 annual budget. In the next few years, the following programs were added: maternal and child health and crippled children's services; tuberculosis control; control of milk and milk products; and dental health.





## Organization

In addition to a look back, the 46 page *Profile of the Colorado Department of Health* describes the health department's organization, gives a summary of each division's activities and the wide variety of programs and services offered to Coloradans.

Also included in the report:

- CDH addresses, phone and fax numbers
- history of public health in Colorado
- CDH organizational chart
- profile of our executive director
- map of local health departments

Brochures on the health department, which give a brief summary of programs, are also available.

For free copies of either, call the Public Relations Office at (303) 331-4609.

# CDC Issues New Immunization Consent Forms

New Vaccine Information Pamphlets published by The Centers for Disease Control will replace the current immunization consent form for MMR, DTP, and OPV. **The effective date for implementation of the new Vaccine Information Pamphlets is April 15, 1992.**

Both CMS and The Colorado Department of Health received a limited supply of camera-ready copies intended to be duplicated by physicians' offices. CMS is in the process of mailing one camera-ready copy of each form to physicians who have previously received immunization forms from us. Those on our mailing list should expect the forms by March 15, 1992.

Consent forms for Influenza, Hib, Hepatitis and Pneumococcal Disease have not changed. If you haven't received the new forms by March 15 you may call Nedra Freeman at The Colorado Department of Health (303)331-8323 to obtain copies.

*The effective date for implementation of the new Vaccine Information Pamphlets is April 15, 1992.*

# HIV and Disability

The Social Security Administration (SSA) has proposed broadening the rules for evaluating disabilities resulting from HIV infection under two existing disability benefit programs. Gwendolyn S. King, Commissioner of Social Security, speaking at a World AIDS Day ceremony, said, "Wherever this disease causes human suffering, we must be there to offer compassion, understanding and vital assistance."

The rule changes make it easier to obtain benefits under the Supplemental Security Income (SSI) program because they expand the authority of SSA field offices to make a finding of "presumptive disability" and begin immediate payments in some cases. Previously, a confirmed diagnosis of AIDS was required for this finding. Now, confirmation of symptomatic HIV infection is

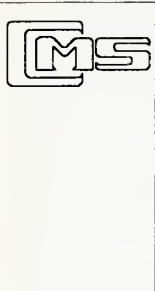
sufficient, if it is severe enough to keep the person from "any gainful activity." In many states, SSI entitlement also means eligibility to Medicaid, so this finding would mean both SSI benefits and Medicaid eligibility could begin immediately.

The changes would also affect the Disability Insurance (DI) program. SSI gives benefits to those whose income and assets are below a certain level. DI pays people starting in their sixth full month of disability and extends Medicare coverage after 24 months. Beneficiaries must also have worked long enough and recently enough in a job that paid Social Security taxes.

The proposed regulations add HIV infection to the SSA's "List of Impairments" meaning it is a condition severe enough to prevent an adult from doing

any gainful work. They also recognize the different progress of the disease in women and men. Gynecological manifestations, for instance, are considered a part of the disability pattern. Different criteria are also used for those under 13. Physicians will be able to use one of two check off forms, one for adults, and one for children under 13, which list the eligibility criteria and allow the physician to check off which are present.

Ms. King says that the SSA "may not have the power to eliminate this tragic epidemic, but we are able to bring greater comfort and dignity to the lives of those affected by it." Call 1-800-772-1213 for more information.



## The Bag Lady

by Suzie Hutchison, MSII

University of Colorado School of Medicine

(reprinted from The Medical Examiner, December 1991)

The first time I entered one of the poorest barrios in Asunción, Paraguay to weigh babies, the children looked at me with their big black eyes, screamed and ran away. I soon learned that not only had these kids never seen a light skinned, freckled blond before, but they had heard stories about "The Bag Lady" in the arroyo (canal). I was carrying a bag and a scale with me so I could weigh the kids and gather information about the level of nutrition in the children, in this community. Little did I know that the parents warn their kids not to play in the canal because "The Bag Lady" will get them. This story is told to keep the children out of the arroyos ridden with excreta and trash.

Through my scattered Spanish and the Peace Corps worker's Guarani (the language of the indigenous population), we explained that we were going to use the bag to weigh the children to make sure they were developing normally. The women scattered into their rickety wooden shacks and changed their children into "cleaner" clothes, then swept the leaves off of their dirt floors and invited us to sit down on their wobbly chairs. It struck me so funny that these people were concerned about being "clean" and hospitable in their impoverished environment. So we started weighing babies, charting their level of development and explaining our findings. Soon the older kids stopped their soccer game in the pathway between the thin wood houses,

the other women stopped doing their washing, the men stopped sipping their teterae (herbal drink) and everybody focused on the big event of the Yankees weighing babies. Seeing these Paraguayans' smiling faces and listening to their laughter took my mind off the foul smell of the half built community latrine and made me happy that I was there helping in the delivery of health care to the children of Asunción.

I was amazed at the positive atmosphere even though these people had nothing. Even their basic one room shacks (housing usually around eight people), were not their own. The barrios sprout up anywhere there is free space around the city. They are illegal although there are no zoning restrictions. A filthy, smelly barrio can be right next to an enormous mansion hidden behind a lavish hedge. The discrepancy between the rich and the poor is astounding. Thirty years under the Strossner dictatorship widened the vast gap between classes. Progress has been made in the human rights arena since 1989 when Rodriquez was elected to head the new democratic government, but little has been done about the thousands of poor Paraguayans.

Despite the apparent filth and destitution, the kids seemed surprisingly healthy. Most had weights appropriate for their age and they looked like healthy, happy babies. We referred the children who looked sickly or were on the low end of the growth curve to the free health clinic we

worked for, Centro de Salud. Food was plentiful, so when malnutrition was a problem it was due to lack of a balanced diet. Manyoka, a high starch vegetable, is the staple in the Paraguayans' diet. Therefore, kids tended to have problems like Kwashiorkor rather than Marasmus. The main health problems among children up to the age of five are diarrhea and respiratory illnesses due to the unsanitary living conditions. Though little can be done immediately about their living conditions, the mortality due to these illnesses can be decreased if the children are well nourished. Therefore, it is important to screen the kids early and educate the parents about nutrition to help prevent subsequent illness.

After a couple hours of weighing babies we said our goodbyes and told them we would be back soon for a follow up visit. I had mixed emotions leaving the barrio that first day. Walking over the creaky, unsteady bridge, acutely aware of the stench of the arroyo, I was so thankful for everything in my life. I felt guilty that I could leave and they could not. I felt lucky, spoiled and caught between two worlds. I felt good that I could help in some small way. I was so deep in my own thoughts that I didn't realize that I had walked past that lavish hedge. I looked up and saw a Mercedes parked under the pillars of a beautiful, shiny new home. What a crazy world! I smiled to myself though, laughing at the image of "The Bag Lady."



# COMMITTED TO EXCELLENCE

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presents the  
winners of  
the 1991*



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Jane E. Gibbs



James E. Peabody

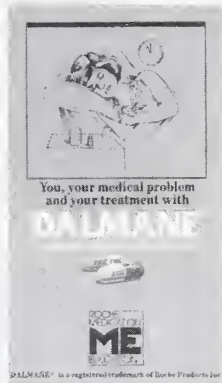
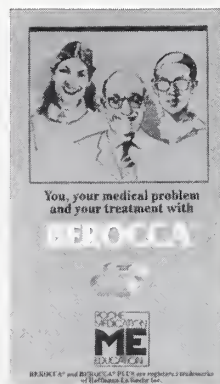
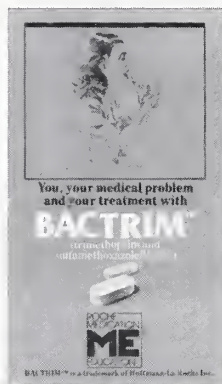


Emily M. Tarleton

# COMMITTED TO TOTAL HEALTH CARE

*Roche  
Laboratories  
presents the  
Resource Library  
for patient  
information*

ROCHE  
**ME**  
MEDICATION  
EDUCATION

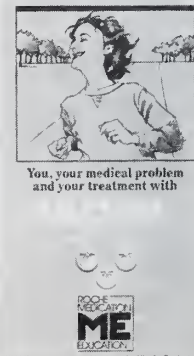
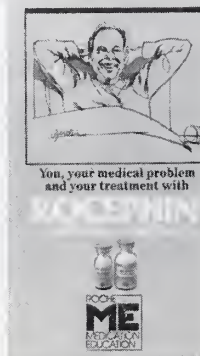
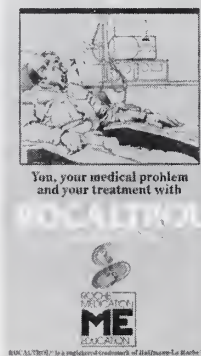
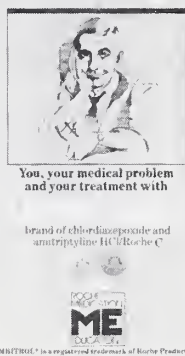
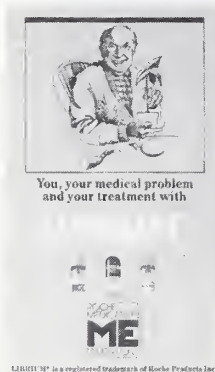


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# Would You Do It, Doctor?

by Thomas H. Coleman, MD

## Youth In Asia

Two or three years ago I asked a world traveler friend of mine what she thought of euthanasia. Just back from her trip to India she said she thought they were very much like young people everywhere. Today she would not mistake the question. The professional and public media are constantly absorbed and fascinated with death, dying and doctors. A manual on how to kill yourself is a best selling book. A new law requires doctors and hospitals to ask patients and their families for decisions about survival and dying, about living wills and powers of attorney. ("Would you want cardiopulmonary resuscitation? A mechanical respirator? A priest?")

In the movie, *The Stepford Wives*, the executive officers of a technology company produce bionic clones of their wives. The programmable clones strangle the wives and smoothly replace them in roles more compliant to the husbands. The wife of the CEO escapes her strangler and runs to her husband in a rage, demanding to hear why he is doing this. "Because we *can*!" he says. With higher motives and hopes we sometimes bring our technology to bear on a dying patient "because we can," often simply because the patient and the family demand it. If results are unfortunate, our dilemma is worse. The patient is gone, but his body lives. Or the patient lives in pain and despondency. In this depressingly slow and expensive phase of a fatal illness, patients and their families turn to us for relief because we have stood by them in terrible ordeals. Our intricate pumps and potions may have brought them through a time of perhaps questionable

value, into situations where we finally have to say there is nothing more we can do. The game is hopeless because we have no ace to play.

## What is the Answer?

There are people who say they can help. We are infiltrated by a graduating class of "ethicists," usually doctors—philosophers, psychologists, psychiatrists—who are trying sincerely to resolve the dilemma. The Dutch are the only nation officially trying a practical way to resolve it with a legalized team. Lawyers, doctors, patients and families make the mutual decision to inject a drug that ends a hopeless existence whose quality and pain are insufferable. The early protocols were troubled by decisions and deaths not entirely mutual or legal, or even compassionate. In 1990, five thousand patients were killed without their consent. Doctors illegally certified them as "natural" deaths. Allegedly there are not more reliable criteria and closer monitoring to stop the abuses, but the Dutch plan is not secure.

Meanwhile, in this country, we have the Humphrys and the Kevorkians. Mr. Humphry, self appointed president of the Hemlock Society, not a doctor, writing about painless suicide, says he stood by while one of his wives killed herself. Kevorkian is an ingenious mechanic with an MD degree who escorts his victims across state lines to be "legal" in the name of mercy. He makes pre-mortem video tapes before his machine connects his "patients" to intravenous poisons. These peculiar men seem to be without normal feelings, operating in a dismal and illegal enterprise.

*Ethical issues abound in medicine. One very persistent question involves the ability to keep the body alive far longer than was dreamed possible a few years ago. In this issue, Dr. Coleman relates this question to traditional concepts of good patient care.*

*continued on next page...*

*"Include me out."*

Samuel Goldwyn

## The Problem is Widespread

Most of us who have practiced long enough will sooner or later have a patient ask for death. Some really mean it. All have some logic, some are humorous. A woman in her eighties, not acutely ill, declared that she and her husband were just living too long. I said there wasn't much to do about that. "But doctor, isn't there something you *could* do about it?" She was quite serious. I said yes, but I would be in a lot of trouble. "But doctor, you *know* we would never tell!" That is logic.

A retired doctor is asking me to leave him a lethal number of pills. He can't seem to care for his colostomy, he's tired of his eighty fifth year and indignant with his expensive nursing home. He resents me because I can't (and wouldn't) help him, easily presuming that the person who should help end his life is his doctor. This same presumption prevails among the people trying to answer euthanasia questions. If a patient is hopelessly ill

and wants to end his life, it seems to me he should be able to accomplish it in some universally accepted legal setting without recruiting a doctor for the final deed. Doctors already have enough personal and legal liability, and enough of death.

## There Are Those

I suppose that when all this is sorted out there may be people, even doctors, willing to be certified as "death angels," but they will have to be protected by law and be the sort who can live comfortably with the guilt of the survivors and their own exceptions to the traditional purpose of Medicine. Until then we must continue to be uncomfortable with the spectacle of a non-professional Humphry and his book, a "professional" Kevorkian with his lethal needle.

Possibly the Dutch are showing us the way to an answer, but so far it seems premature for a physician to be identified with it. To quote Sam Goldwyn of the movies, "include me out."

# Are You Current With Current Procedural Terminology?

The American Medical Association has assembled a number of resources for use in coping with the changes made recently in Current Procedural Terminology (CPT) codes and reimbursement from Medicare. You will need at least some of this information in order to properly code claims in the coming months.

*CPT 1992* is the primary resource book for these codes. In addition to the main list, minibooks provide specific information on specialty areas and there is a version for hospital outpatient services. Some of these are also available on floppy disk or magnetic tape.

There is now also a quarterly newsletter called *CPT Assistant* which is designed to provide practical sugges-

tions for coding on a day to day basis.

Another major resource is *Medicare Physician Payment Reform: The Physicians' Guide*. This two volume set provides physicians with the most recent information on RBRVS and explains its background and history. A good companion would be *Estimated Changes in Payments to Physicians* which helps physicians and administrators estimate the impact of the RBRVS on their practices.

*The Physicians' Guide to Medicare* is a subscription binder that provides a complete, easily understood overview of the Medicare program. In addition to providing replacement pages for the binder, this subscription includes a semi-monthly newsletter on Medicare policy and other changes.

The resources are not limited to print media, however. A video called *Physician Payment: Implementing RBRVS* will be the first of six video journals to be produced in 1992 on critical issues. In addition a Workshop called Medicare's New Physician Payment System provides a review of RBRVS, discusses new CPT visit codes and anticipates regulatory and legislative changes. This also includes a presentation from Health Care Financing Administration (HCFA) officials on the Medicare program's philosophy and methodology.

For information on the publications or the video, call 1-800-621-8335, (for *Physician's Guide to Medicare*—800-248-3248). To find out about the workshops call 800-366-6968.



# Physician Professional Marketing

## A Personal Opinion

by George E. Burdick, MD  
Associate Editor, Arizona Medicine

Medical marketing has become a controversial issue for physicians. A number of factors affect this controversy, not the least of which are issues that obscure what is and what is not physician advertising. With these concerns in mind I attended the recent Quarterly Meeting of the Maricopa County Medical Society. The guest speaker was Mark Paston, Ph.D., Professor of Marketing.

Dr. Paston's theme was that aggressive marketing is not always unethical. He provided many examples with which most of us would agree. It was his feeling that the private practice would need to be aggressively marketed in order to survive. Examples he used when describing professional marketing we might label differently. For example, lecturing on topics in our field I would consider continuing medical education rather than marketing. Providing expertise to community organizations, serving on Boards of Directors for non-profit organizations, etc. I would call volunteerism. There are a number of activities Dr. Paston would call marketing, of which I would hope we are all guilty. We should continue to volunteer our professional expertise in areas of education, community volunteerism, local civic organizations, etc.

It is when Dr. Paston comes to true advertising that most professionals, particularly physicians/attorneys, have difficulty with the ethical standards applied. Most of us feel people who claim a fiduciary relationship with patients/clients lose credibility when they advertise.

Another disturbing feature of advertising is that it avoids established methods of obtaining quality medical care. Throughout the history of American medicine there has been a tradition of how one finds the way into specialty care, in particular. Patients have a primary care physician with whom they consult, to help them determine if, in

fact, they are in need of specialty care. In my opinion, this process has worked extremely well. These patients are usually guided into the office of specialists or other health care facilities which share the basic professional values of the primary care physician the patient has chosen. Advertising subjugates this entire process for one that is not as likely to benefit the person seeking health care.

Dr. Paston was quick to point out that many businessmen, salesmen, contractors, etc., do, in fact, conduct themselves in a highly professional manner and objected to my suggestion that these individuals were less trustworthy. I would agree with Dr. Paston in that we all appreciate those individuals that we can trust, whatever their field of endeavor. These people are, in fact, treasures in our environment as we try to obtain quality services in our day to day lives. Physicians, on the other hand, are required by their oath, their ethics and the law to provide the services which are beneficial to their patients. Our financial concern in our interaction with patients is whether a particular test, medication or procedure is cost effective to our patients, not to our personal checking account. Once a physician or an attorney advertises, claims to a fiduciary relationship with their patients or clients are suspect.

Perhaps former Chief Justice Warren Burger said it best when addressing the American Bar Association a few years ago. I will have to paraphrase his remarks, but essentially he said that advertising may be legal, but that it was not professional.

Perhaps Dr. Paston is correct when he stated that the private practice of medicine will need to advertise in order to survive. I frankly doubt this is the case; but if the private physician has to compromise his professionalism to survive, is private practice worth saving?

*"My personal opinion is that advertising does nothing of benefit and raises the overall cost of medicine.*

*It guides prospective patients into health care facilities of various types, for the wrong reasons. Particularly disgusting are ads for health care plans and hospitals which inundate us from TV sets and billboards. In my opinion, there is a reasonably strong negative correlation between the degree of advertising and the quality of the organization involved."*

*George E. Burdick, MD*

# Board of Directors Report

## Highlights of the Board of Directors Meeting, January 31, 1992

### Executive Committee

MSC to form a committee/task force to determine ways and means to assist with the medical crisis in Russia.

Dr. Butler reported on the meetings which have occurred with Governor Romer regarding health care reform in Colorado and actions taken by CMS to respond to the Governor's request for recommendations from CMS. A resolution will be prepared to submit to the HOD for further action.

### Finance Committee

The Board ratified the actions of the Finance Committee in approving grants to the Colorado Physician Health Program and the Colorado Personalized Education for Physicians Program.

### Auxiliary

Ms. Diane Duffy-Glismann reported that Legislative Day was January 27th and that it was successful. CMSA collected over \$600 in contributions to be sent to AMA-ERF in honor of their spouses for Doctors' Day in March. CMSA will hold their House of Delegates and Installation of Officers on April 30th.

### AMA Delegation

Dr. Joel Karlin reported on the activities occurring at the recent AMA Interim Meeting, indicating that the major emphasis was placed on 1) RBRVS, 2) Health Access America, 3) HIV testing and 4) Managed care.

## Highlights of the Board of Directors Meeting, October 25, 1991

### Executive Committee

Dr. Butler reported that a meeting had been set to meet with the Executive Director and two representative of the BME to discuss their review procedures.

### CMS Auxiliary

Mrs. Pam Laman, CMSA President-Elect, thanked the CMS membership for the actions taken at the HOD in approving the CMSA representative to the Council on Legislation.

### Finance

The Board ratified the actions taken by the Finance Committee to increase the per diem rate for CMS related travel expenses to \$215 per day.

### Action Items

MSC to develop a survey, using a variety of sources, to be sent to the CMS membership as soon as possible regarding the subject of and issues surrounding AIDS. Results of the survey will be used to determine future legislative actions taken by CMS.

MSC to approve holding a Leadership Conference during the summer.

MSC to conduct the Board of Directors meeting at the Annual Meeting in September, 1992.





# Mile High News

1990-1991 Vol. 4, Issue 2

Colorado Medical Society Auxiliary

November, 1990

*Susan Larkin, Editor*

## Message from the President:

I strongly urge each and every one of you to join me on Thursday, April 30 and Friday, May 1 for our House of Delegates and Installation of officers.

Our setting will be the Hotel Georgio which is providing outstanding rooms at moderate prices. See this issue for your reservations.

By way of review, the composition of the House of Delegates is as follows: state officers, chairmen and members of standing committees of the Colorado Medical Society Auxiliary. Each County Auxiliary is entitled to a presidential delegate and a delegate allocated on the basis of state membership in accordance with the following guidelines:

- 1-50 2 delegates
- 51-100 3 delegates
- 101-150 4 delegates
- 151-200 5 delegates
- 201-250 6 delegates

The counties may have an alternate for each delegate position. All delegates and alternates must be state Auxiliary members. All members of CMSA are encouraged to attend all meetings of the House of Delegates.



Our AMAA guest speaker this year is Sharon Scott of Roseburg, Oregon. She is Western Region Director and a member of the Finance Committee of the AMAA.

Additionally, we plan to have an interesting dinner speaker on Thursday evening.

Your job as a delegate is tremendously important since you are representing your county Auxiliary in setting policy for the CMSA. You are the grass roots. We need your participation in the decision making process and we need your enthusiasm at this annual meeting.

We are counting on your input to link all levels of auxiliaries, from County to State to National. This network facilitates exchange of ideas, projects, resolutions which benefit our

entire organization.

Submit your resolutions and be a decision maker and contribute to the success of our meeting April 30, May 1.

SIGNATURE

## IN MEMORIAM

### Catherine and Frank Yoder

As individuals and as a couple, their lives exemplified many of the ideals that we, as members of the Colorado Medical Society Auxiliary, endeavor to uphold... enthusiastic devotion to each other, to their family, to their community and to all causes that they believed in.

Catherine and Frank contributed greatly to our organization and to the lives of all of us who knew them. We shall surely miss them. We extend our heartfelt sympathy to their family.

**COUNTY PRESIDENTS:** Please send me your **ANNUAL REPORT** and **RESOLUTIONS** before April 1, 1992

**COUNTY PRESIDENTS-ELECT:** Please send me your picture by March 30, 1992 for our April Mile High News .



## Are You Spending Your Volunteer Energies in the Right Place?

This was the topic of discussion at the CMSA Western Regional Meeting held in Grand Junction Nov. 13, 1991.

Diane Duffy-Glismann (CMSA Pres.) and Pam Laman (CMSA Pres.-Elect) flew to the Western Slope to join us in a program conducted by Janet Cameron, Director of Human Resources at the Resource Center.

Many suggestions and ideas were presented regarding volunteerism. She stressed that we should recognize our group's personality, focus on an issue/project, look at the time commitments needed as well as what is available and match it to the needs identified in the community.

We were impressed by the effectiveness of our local Resource Center in its accomplishments while operating on a shoestring. They have made great progress in terms of domestic violence, teen pregnancy, family and employment training. Our long range team meets this Spring and supporting this very dynamic organization may prove to be our major thrust this next year.

*Eileen Lepisto, Western Regional Director*



*(l to r) CMSA President-Elect Pam Laman, Janet Cameron, Director of Human Resources, Mesa County Resource Center, and CMSA President Diane Duffy Glismann enjoy the fellowship at the Western Regional meeting.*

## DOCTORS' CARE —Arapahoe County

Arapahoe Medical Society's Doctors Care program is opening their Sick Child Clinic in April, 1992. This program involves approximately 75% of the Arapahoe Medical Society's 500 physicians. They provide uncompensated medical care to Arapahoe County families who are uninsured and unable to afford medical care.

DOCTORS CARE arose in response to the decision by Denver Health and Hospitals to not accept suburban patients in its facilities. The doctors originally anticipated that it would try to meet the needs of low income patients in southern Arapahoe County through the services of volunteer physicians until primary care clinics were established in Arapahoe, Douglas and Elbert counties. These never materialized but DOCTORS CARE has persisted and grown. In its three years, this program has served about 2700 clients, predominantly women and children. All are uninsured, low income poverty level individuals or families that have limited access to care. Many of the DOCTORS CARE clients are those that have "fallen through the cracks" of the health care system. Most have jobs, but are unable to qualify for Medicaid. DOCTORS CARE recognizes the need to acknowledge those that are trying to live independently from government subsidies.

The Arapahoe County Auxiliary has been assisting with both volunteer hours and financing in this project, raising nearly \$800.00 in December with the very successful joint venture with the Swedish Hospital Auxiliary "BREAKFAST WITH SANTA".

The clinic is accepting any in-kind office equipment or financial contributions. Watch for the Grand Opening date. You are invited to share with us in the new venture.

*Barbara Rohrer  
President, Arapahoe County*

## PROJECT CARE

Project Care warrants some attention! Last summer when I met with Diane Duffy Glismann, I was pleased and excited to accept the co-chairman position for Project Care. Now that I have had some time to "settle into" the co-chairmanship, I want to talk about the project and what I can offer the auxiliary.

Project care is a peer support program. As co-chair my role is to give support, provide information and suggest resources to any auxiliary member who is experiencing stress or emotional trauma in her life for whatever reason. Medical families deal with the usual stress and trauma that any family must deal with but we also have problems that are unique to the medical community. Sometimes we need a peer that understands what we are feeling and what we are struggling with in our lives.

My professional training adds an extra dimension to my role with Project Care: I have a Masters Degree in Counseling and I am a Certified Addiction Counselor. Because I am active in the professional community I keep current on information and resources available in the area. Most importantly, my professional ethics dictate that confidentiality is strictly observed. Asking for help or support is a difficult step to take and knowing that our identity is safe allows many of us to take that step.

Project Care is an important part of the Auxiliary and is there to provide a resource for medical families. I feel honored to be part of the program. Please don't hesitate to call me at 832-5434 if you think I can be of help to you. I am available to do educational workshops or facilitate group discussions. I would welcome any suggestions you might have to let medical families know that Project Care is available to them.

*Carol Michalek, MA, CACII  
Co-Chairman, Project Care—(823-5434)*



## Colorado Medical Society Auxiliary—House of Delegates

**Thursday April 30, 1992**

11 am Board of Directors meeting

1:30 pm House of Delegates

5:00 pm Social Hour

7:00 pm Dinner—Keynote Address

Sharon Scott, AMAA Western Region Director

**Friday May 1, 1992**

9:15 am Registration & Coffee

9:45 am Welcome & National Update: Sharon Scott

10:00 am Installation of Officers

Gavel Club Skit!!!!!!

CONCLUSION BY 12:30

NOTE: Hotel room reservations should be made directly with the Loews Giorgio Hotel at (303) 782-9300. \$74 per room. Please mail meal reservations to **Barbara Rohrer**, 5449 E Long Pl, Littleton, CO 80122.

**Thursday Dinner**

Choice #1—Roast duck—\$38 (includes tax)      Choice #2—Grilled swordfish—\$40

**Friday Brunch**

Gourmet salad, Grilled chicken breast, Crusty breads, Dessert—\$20

## NEXT YEAR...

The Nominating Committee of the Colorado Medical Society Auxiliary submits the following candidates for office for 1992-93

**President-elect**

Pam Laman (Muryl) Pueblo

**Vice President**

Patti Benson (Alan) Longmont

**Recording Secretary**

Barbara Rohrer (Harold) Arapahoe

**Treasurer**

Carol Carona (Joe) Weld

**Treasurer-Elect**

Mary Jo Ryals (Jarvis) Pueblo

Other nominations may be made from the floor providing each nomination is accompanied by written consent of the nominee. These people will be placed in nomination at the General Meeting and will be voted on at that time. If elected, they will take office April 30, 1992.

*Submitted by: Doris L. Ballinger (chairman) representing the 7 member nominating committee.*

## RESOLUTIONS—HOUSE OF DELEGATES

**Whereas** the American Medical Association considers women the gatekeeper of family health, and

**Whereas** 90% of American women are responsible for planning meals, shopping for food and seeing to the nutritional and health needs of family members, and

**Whereas** the AMA Auxiliary is working with the AMA on it's Women's Health Campaign to educate women about their own and their families' health, and

**Whereas** topics being addressed include breast and cervical cancer, smoking cessation, reproductive health, heart disease, stress and depression, as well as nutrition, and general health and fitness.

**Be it resolved** that the CMSA works with the Colorado Medical Society in keeping the care givers healthy. This can be accomplished by teaching medical families what they need to know to address their families' "health needs."

**Be it further resolved** that the Auxilians endeavor to be role models for their families and the community by seeking access to prophylactic examination of breast and cervix for all women according to AMA guidelines.

#2—**Whereas** the American Medical Association considers smoking to be the number one drug addiction in the United States, and

**Whereas** exposure to tobacco smoke ("passive smoking", "side stream smoke") has clearly been demonstrated to be harmful to nonsmokers, and

**Whereas** the United States Government is waging a major war against drugs, and

**Whereas** attempts to convince young adults and children to not use drugs have no credibility when they see their elders and adults smoking,

**Be it resolved** that the Colorado Medical Society Auxiliary urge government officials and legislators to enact ordinances or legislation to prohibit smoking in Coors Stadium, Mile High Stadium, Stapleton International Airport, Denver International Airport, and all other municipal buildings.

#3—**RESOLUTION** presented by the CMSA Gavel Club for consideration at the April Meeting:

**Whereas**, it is more critical than ever before for CMSA to provide strong support to the Colorado Medical Society and to the profession of medicine as a whole, and

**Whereas**, it is important that all areas of our state become active in this endeavor, and

**Whereas**, it is a real privilege and pleasure to share our time and talents by working closely with other physicians spouses around the state, be it hereby

**Resolved** that County Auxiliary members be urged to encourage participation in state leadership, by consenting to serve themselves and/or by strongly supporting fellow auxilians to accept state positions.

## BYLAWS CHANGE

The following amendment to the CMSA Bylaws is recommended by the Bylaws Committee:

**ARTICLE VI, Section 3A-** Delete this section.

Delete the letter "B" = making the present Section B the entire Section 3 of this Article.

Rationale: To allow the President/President-Elect to serve an additional one year term in special circumstances.

## AMA-ERF

Fund raising efforts are being enthusiastically carried out by all the counties in Colorado. Our goal this year is to increase our donations by 2%. We are well on our way and it is a realistic goal! The dollar amount to strive for is approximately \$20,000.

We're way over half way there — and we know we can do it! Please consider an additional fund raiser before the end of your auxiliary year. Your AMA-ERF co-chairmen are ready to help in any way we can. Please contact us for more information.

**Rose Pollard** (719) 622-0411, 1432 Bellaire, Colorado Springs CO 80909

**Mary Hanson** (719) 576-1463, 2878 Tenderfoot Hill St, Colorado Springs CO 80906

Please look elsewhere in Colorado Medicine to note the list of physicians honored by a donation to AMA-ERF by their spouses on the CMSA Board of Directors.



## ABOUT OUR NATIONAL GUEST:



**SHARON SCOTT** (James) Of Roseburg, Oregon, serves as a director of the western region and a member of the Finance Committee of the American Medical Association Auxiliary.

Mrs. Scott previously served at the national level as a member and chairman of the Membership Committee. She has also served her state auxiliary as president.

Mrs. Scott has been involved in a variety of other volunteer efforts, including editor of the Steamboater newsletter, member of the Library Foundation Board, the State Advisory Committee for Comprehensive Health Education, and the School Budget Committee. Mrs. Scott holds a bachelor of arts in education and a masters degree in English.

Prior to her marriage to James Scott, MD, an otolaryngologist, she was a high school teacher and currently teaches high school Forensics in addition to working in her spouse's office. Dr. and Mrs. Scott are the parents of four children.

## NEWS—NOTES—REMINDERS— APPLAUSE—ETCETERA...

**DENVER MEDICAL SOCIETY AUXILIARY** reminds all that the annual Buffet-Dinner honoring the doctors of the DMS will be April 6, 1992—DMS Bldg. 1850 Williams

*Sally Barton, Chairman*

**HALL OF LIFE COFFEE AND EXPERIENTIAL TOUR**  
The Denver Museum of Natural History

March 24, 1992—9 AM

This is a fund-raiser to pay admission to the facility for school children. Reservations are by check to the DMSA, Hall of Life for at least \$15.00. Mail to Doris Craigmile, 4431 E. 6th Ave. Denver, CO. 80220. Deadline March 20 General Meeting 10:00 AM

*Peggy Humphries, President*

**THANKS:** to Sue Magee and Sondra Talley! Their fine descriptions of their Auxiliary's involvements in their communities appeared in *FACETS* the January issue of our national magazine!

## LEGISLATIVE AFFAIRS REPORT

The Colorado General Assembly is in session and the CMS and CMSA are interested in several medically related bills PLEASE read the section in *Colorado Medicine* titled "The Lobby". The CMS staff and Alan Rapp, MD, Chairman of the CMS Council on Legislation, provide us with an in-depth report on what is happening and how it affects us. The CMSA Legislative Affairs Chairman is now a voting member of the CMS Council on Legislation.

"PARTICIPATION '92" is an AMA program to encourage its members and auxiliary members to participate in the election process. On November 3, 1992, Americans will go to the polls to elect a President, 35 US Senators, 435 US Congressmen, 12 Governors and thousands of state and local officials. All Colorado Representatives and half of the state's Senators will be up for election. Get involved. Interview incumbents as well as candidates. Force specific answers. Don't settle for political rhetoric. Plan those meetings with the candidates, chose who you like and help with his/her campaign. Plan voter registration days in your community and MOST IMPORTANTLY: VOTE. The County officers have the lists of which Colorado Legislators are up for re-election. Please ask them to share the information and make your plans accordingly.

MARCH 3, 1992 is Colorado's FIRST Presidential Primary. You must declare a party preference to vote in your party's primary.

*Patricia B. Brown, CMSA Legislative Affairs Chairman 1991-92*





## 1993 INTRAV Trips Announced

Colorado Medical Society cooperates with INTRAV, a world renowned travel agency, to bring its members the finest in travel accommodations. Each year, medical society members receive attractive travel brochures describing the various trips which will depart that year. In the recent words of one member, "I had seen these brochures come across my desk year after year and I would dream. This year I decided 'Now is the time!'" That member is planning a special anniversary trip to the land of the midnight sun.

Ric McCune, Regional Vice President of Sales for INTRAV, has announced our 1993 departures. In April, members will be able to travel to the Canary Island and Morocco. Another popular trip is back in '93, the wings over the Nile trip, this year highlighted by a trip to 1,400 year old St. Catherine's Monastery.

Our 1992 anniversary couple will be able to repeat their memorable Midnight Sun Express and Alaska Passage

trip if they desire and the newly popular Great Waterways of Russia will return this year. If watching the cutting edge of world history in Russia is not for you, visit the Great Rivers of Europe. The land of the Vikings will be featured in a tour of Scandinavia and there will be an Air/Sea Cruise to the Mediterranean and Black Seas.

French Canada and the northeastern coast will be seen by those on the Canada/New England Air/Sea Cruise. Those who served in Desert Storm may want to visit other sites in that part of the world on the Passage to Suez tour of Turkey, the Greek islands, Israel and Egypt. The very popular Wings over Kenya Air Safari will fill up quickly.

These trips depart in 1993. Brochures have already gone out for 1992 departures. Watch your mailbox for more details.

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*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

### **LDS Hospital/University of Utah**

Ethics Committees and Morality Plays: A Shared

Search for Virtue

Salt Lake City, UT

March 13, 1992

(801) 321-1135

### **University of Arizona**

Epilepsy & Behavior

March 14, 1992

Tucson, AZ

(602) 626-7832

### **Univ. of Calif. Med School Dept. of Radiology**

Radiology in Asia

Singapore, Bali, Bangkok, Hong Kong (option to

Beijing and Kweilin)

March 14-27, 1992

Dawne Ryals (404) 641-9773

### **Colorado Communications Consultants**

English Accent Modification

Denver, Colorado

March 25, 1992

Terry Evans or Poorna Crampton, (303) 421-4154

### **Colorado Safety Association**

Rocky Mountain Health & Safety Conference

Colorado Convention Center, Denver

March 25-27, 1991

Melodye Turek (303) 373-1937

# CMS Med Fax

## **American Lung Association of Montana**

Big Sky Pulmonary/Ski Conference

Helena MT

March 25-29, 1992

(406) 442-6556

## **N.U.R.S.E.S. of Colorado**

Impaired Peer Assistance

Radisson Hotel, Denver

March 28-31, 1992

(303) 758-0596

## **Office for Substance Abuse Prevention**

Peer Assistance: A Model for the Helping Professions

Hyatt Regency Denver

March 28-31, 1992

800-765-0263

## **American Society of Addiction Medicine**

23rd Annual Medical/Scientific Conference

Washington, DC

April 2-5, 1992

Virginia Roberts (202) 244-8948

## **World Congress on Healthcare**

World Congress on Healthcare (live broadcast)  
from New York by satellite

April 8-9, 1991

Mike Dulligan (800) 879-3857

## **Hilltop Rehabilitation Hospital/UCHSC**

Early Intervention of Industrial Injuries

Snowmass Village, Colorado

April 9-11, 1992

(303) 244-6193

## **Harvard Medical School**

Mothers: Victimization, Stigma and Survival

Children's Hospital, Boston, MA

April 22-24, 1992

(617) 432-1525

## **American Academy of Neurology**

Annual Meeting

San Diego CA

May 3-9, 1992

(612) 623-8115

## **World Congress on Healthcare**

ASH Annual Meeting (live broadcast)  
from New York by satellite

May 7-11, 1991

Mike Dulligan (800) 879-3857

## **Presbyterian/St. Luke's Healthcare System**

Born Too Soon: The Fetus as a Patient

Red Lion Hotel, Denver

May 9, 1992

Mary T. Fletcher (303) 869-1900 or 800-633-8824

## **World Congress on Healthcare**

World Telecommunications Conference (live broadcast)  
from New York by satellite

May 20, 21, 1991

Mike Dulligan (800) 879-3857

## **American Academy of Pediatrics**

Perinatal Pediatrics Conference

Kauai, Hawaii

May 21-24, 1992

L. Joseph Butterfield, MD (303) 861-6509

## **American Medical Association**

Financial Strategies for Retirement

Denver, Colorado

June 5, 1992

(312) 419-5042

## **Rush-Presbyterian-St. Luke's Medical Center**

Cytokines and Transplantation

Chicago, IL

May 30, 1992

Suzanne Buss (312) 942-6242

## **American Medical Association**

Successful Money Management

Denver, Colorado

June 6, 1992

(312) 419-5042

## **Univ. of Calif. Med School Dept. of Radiology**

Radiology in Africa

Nairobi, Samburu, Kenya, Masai Mara

October 10-24, 1992

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## Colorado Gynecological and Obstetrical Society

### You Still Have Time to Register

The President's Symposium will be held Friday, March 13, 1992 at the Hyatt Regency Denver Tech Center. The morning topic is sexual and domestic abuse and the afternoon topic is AIDS. Marilyn Van Derbur Adler will be the morning keynote speaker and Ken Hamblin will be the luncheon keynote speaker. The Symposium will be held from 8 am to 4:30 pm and Continuing Education Credits will be available. The cost is \$20, which includes lunch. This will be an outstanding, unique Symposium. Registration can be taken by phone up until 3 days before the event by Betsy Fox at 355-8845.

### Membership Meeting

The "Gottesfeld Lectureship" will be held at the Marriott Hotel, I-25 and Hampden, on Monday, March 2, 1992, with cocktails at 6 pm, dinner at 6:45. Dr. Irwin Merkat, Chairman of the Albert Einstein College of Medicine, will be speaking on New Priorities in Pregnancy Care. For more information, contact 693-6127.

### Legislative Dinner

The Annual Legislative Dinner will be held Wednesday, March 11, 1992, at the Oxford Hotel, in the Sage Room, from 5:45 pm until 8 pm. The topic will

be the future of Women's Health Care.


### Legislative Breakfast

The Annual Legislative Breakfast was held on Valentine's Day, February 14th, and was very well attended. Many Society members attended to represent the Society and numerous Legislators expressed their thanks for the breakfast. Wyeth and Tokos supported this event.


### ACOG District VIII Legislative Meeting Held in Denver

The Colorado Gyn/Ob Society hosted an ACOG District VIII Legislative meeting in Denver on Saturday, November 2 at the Scanticon. This special legislative meeting hosted ACOG members from Alaska, Arizona, Montana, Nevada, New Mexico, Oregon, Wyoming, British Columbia and Colorado. There were 36 attendees. The successful legislative program was designed by lobbyist Peggy Walker. The purpose of the day was to give participants a good idea of what it takes to create and implement legislation, and entailed role playing, presentations and a great deal of valuable discussion. It was held in Denver as an acknowledgment of the successful lobbying and community relations programs that have been developed by the Colorado chapter.


*The Colorado Gynecological and Obstetrical Society is one of the many specialty societies in the state serving the interests of physicians who concentrate on a particular area of medical practice. For more information on their activities, contact Betsy Fox at 355-8845.*




*"Nah,  
I've smoked  
for  
30 years.  
It's too late."*




*"I've tried a  
million times,  
but I just  
can't."*




*"I'll  
quit  
next  
week."*




*"What difference does  
it make? I'm already  
52 years old."*




*"I'll quit  
next year."*



*"It's one of the  
few pleasures  
I have left."*



*"I've got  
other things  
to worry about."*



*"The damage  
is done."*

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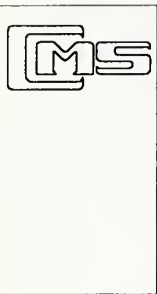
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# Colorado Medicine

April, 1992

Volume 89, Number 4



University of Maryland  
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## Doctor Caring Spans the Ages

IM '92 House of Delegates Faces Weighty Issues

See Page 133

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APR 17 1992

Also in this Issue...

CMS President Advocates Changes in Procedure for the Board of Medical Examiners

*Harrison G. Butler, III, MD*

Dr. Mark Levine Notes the Caring Capacity of Health "Care" Professionals

Colorado Gynecological and Obstetrical Society



P. 109

REC'D

NOT IN

P. 114

P. 140

**SPECIAL INSERT**  
Copic Report to the CMS  
Things You Need to Know



# Goals Vs. Performance



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## Cover Story

Whether able to offer counsel and support, high tech wizardry or debate on heavy societal issues, the hallmark of the physician has been an attitude of *caring* for patients. See Dr. Mark Levine's comments on health "care" for an interesting perspective on the recent debates of the House of Delegates.



## Departments

- 109 President's Letter
- 111 Executive Director Update
- 119 The Lobby
- 126 Health Department
- 129 Health Care Financing
- 133 Interim Meeting 1992
- 139 Medical News
- 140 Specialties
- 141 Classified Advertising

## In This Issue...

- 109 Physician Input to the Board of Medical Examiners  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 113 Ruminations—The past speaks again
- 114 Caring About Health Care—What Medicine is All About  
*An address by Mark A. Levine, MD, Denver,*  
*to Senior Days at the Capitol*  
*February 26, 1992*
- 117 Rural Health: CARING for the country
- 118 "Rural Lifestyles" —Helping Students Care About Health
- 124 Time for the 1992 Directory—Have YOU returned your card?
- 132 Letter From an Editor—Can Fidelity and Politics Mix?  
*by Leslie Moldauer, M.D., Denver*  
*Editor: Colorado Psychiatric Society Newsletter*

### SPECIAL INSERT

Copic moves into its second decade: A report  
*George O. Thomasson, MD*  
*Vice President, Risk Management*

- 133 Interim Meeting 1992—Lots of Issues, Lots of Interest: Here is what happened.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor





Harrison G. Butler, III, MD  
President, 1991-1992

Representatives from the Colorado Board of Medical Examiners (BME) and the Executive Committee of the Board of the Colorado Medical Society met March 12th to consider concerns voiced by the membership. Resolution 33-P, introduced by the Pueblo County Medical Society, mandated that we meet with the BME and discuss the opportunity for a physician to appear face to face after he/she responded to the "twenty day letter" and before referral of the matter to the Attorney General's office.

The meeting was cordial and frank. The BME was represented by the President of the Board, Jan Ugale, MD, Gil Herman, MD, and Rene Cousins, MD. Tom Beckett, Administrator of the BME, was also in attendance.

There is no question in my mind that the physician members of the BME are overworked and remarkably undercompensated (they are paid \$50 per day plus, they have to pay physicians to cover their practice on those days spent with the Board). I am also convinced that they are genuinely concerned about fairness to both the physician and to the citizens of the state of Colorado. This fairness is where the conflict occurs.

Jan Ugale argued convincingly that their mandate is to represent and protect the citizen/patient, but at the same time, weigh the severe consequences to the physician in the event of sanctions.

By state law, any complaint received by the Board about any physician, must generate a "twenty day letter." It became crystal clear that it is in the best interest of the physician to reply to that letter personally. Physicians read these responses and look

more favorably on a personal response than on a twenty page treatise from a lawyer.

After the Board reviews the reply to the twenty day letter, it can dismiss the complaint, ask the Department of Regulatory Agencies to investigate the complaint, or, in unusual circumstances, refer the matter to the Attorney General's office.

If the decision is to investigate the matter, the information received as the result of the investigation is reviewed in detail by the Board. The panel can then either send a Letter of Concern, which is a *dismissal* letter, a Letter of Admonition or refer to the Attorney General's office.

The Board members in attendance were careful to point out that each case is reviewed by physicians in the same specialty and in a similar geographic and practice circumstance. They must accept that specialist's opinion and cannot "shop around" until they get an opinion they like.

The Letter of Admonition is a serious sanction. This must be reported to the National Practitioner Data Bank, the physician's hospital and the physician's liability insurance carrier.

Finally, based on the *written* evidence, the Board can refer the matter to the Attorney General's office. The Attorney General can then negotiate a stipulation or recommend a revocation of license.

It is with the Letter of Admonition or referral to the Attorney General that the physician should get the advice of a lawyer. If the physician so elects, he/she can go before an administrative law judge and receive a full hearing. The administrative law judge then sends

*"The physician members of the BME are overworked and remarkably under-compensated. I am also convinced that they are genuinely concerned about fairness to both the physician and to the citizens of the state of Colorado."*

*"Lawyers become involved, which means...a 'scalp' mentality may take over."*

recommendations back to the Board, who must decide either to dismiss or levy punishment. Recently, the Board has agreed to hear the physician in person before they decide on punishment. This is the first and maybe the last time a physician can appear before the Board to personally plead his/her case. If the decision by the Board is unfavorable, the case can be appealed to the civil courts.

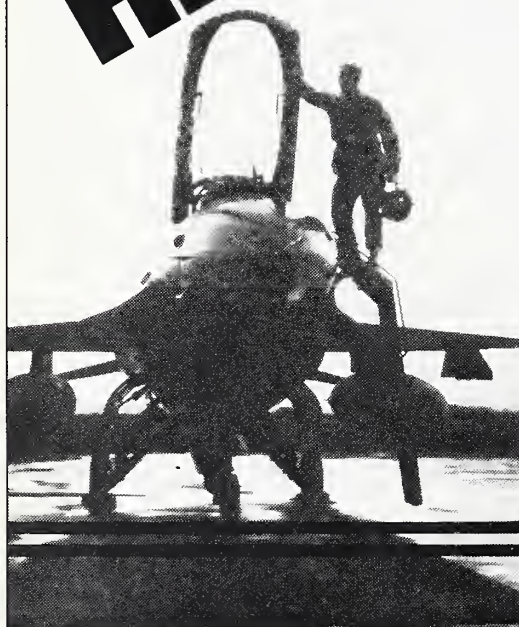
Pardon me for going through this process, but it seems to me that this can be improved. There should be some measure of due process for the physician before the matter goes to the Attorney General. If this is referred to the Attorney General's office, lawyers become involved, which means an enormous amount of time and money expended. Further, I worry that at this point a "scalp" mentality may take

over, spurred by the self-appointed, anti-physician and hysterical "Nader-ites."

Why not let the physician and the person with the complaint appear before the Board after the investigation is complete and before a decision is made to issue Letters or refer to the Attorney General's office? In my mind, this could make the matter more clear, not only to the Board, but also to the physician and to the person with the complaint. I hope that this would reduce the number of cases going to the administrative law judge. That should help everyone.

Finally, the physicians doing the thankless work of the Board of Medical Examiners deserve our help and our praise. Without them, the practice of medicine would not be as professional and sacred as it is now. My personal thanks goes out to these physicians!

**AIM  
HIGH**



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by **Montgomery Little Young Campbell and McGrew, P.C.**

legal counsel to the Colorado Medical Society

## New Physicians Have Allies

Both of Colorado's Senators are co-sponsors of legislation designed to repeal reduced fees for physicians in their first four years of practice. Senator Tim Wirth and Senator Hank Brown joined Senator John McCain as original co-sponsors of a Senate Bill which would amend Section 1848 of the Social Security Act to make payment under the Act to all physicians equal, regardless of length of practice.

Senator Brown said, "Currently, new physicians in the Medicare program are paid 20 percent less than established Medicare providers for services rendered during their first year of practice. As a result, the rule has become a significant deterrent for new physicians considering a practice in rural areas of our state. This legislation represents the type of practical and useful health care reform that Congress needs to consider."

The act speaks of physicians new to Medicare, leading Senator McCain to note that physicians who had served years in the military would face reduced payments when they enter private practice, since they would be viewed as "new physicians." The act mandates not only the 20% reduction in the first year, as noted by Senator Brown, but also 15% in the second year, 10% the third and 5% in the fourth year.

Several CMS members have been active in advocating such legislation. Dr. James Regan, the Colorado delegate to the Young Physician Section (YPS) of the American Medical Association (AMA) and Dr. Dieter Schneider, Immediate Past Chair of the CMS-YPS and Board Member of CMS, have worked on behalf of such an equalization. Dr. Regan told *Colorado Medicine*, "The Young Physician Section is very excited about it. The whole thing is sort of ludicrous, the way it exists." In his March report to the House of Delegates on behalf of the YPS, Dr. Regan pointed out that "Eighty-one percent of 1989 graduates from medical school carry a debt of at least \$42,374 and 29% had debts in excess of \$50,000. Ninety-one percent of minority graduates were in debt and 41% of minority graduates had debts exceeding \$50,000. There certainly exists no data to

indicate that young physicians have lower resource costs for their practice and in fact the cost of education, lost opportunity costs for years of training, professional liability costs, and costs of starting a practice are in fact in many cases higher for new physicians than others. The existing guidelines may indeed discourage physicians from seeking training in the lower paying specialties because it is apparent that they must meet their educational and other debts." He urged that all physicians contact their Senators and Representatives immediately to urge passage of this legislation.

In addition, Dr. Robert Bogin, Immediate Past-Chair of the AMA-YPS and presently the CMS Alternate Delegate to the AMA, has advocated such an approach. Dr. Bogin spoke to the House of Delegates March 7 about the need for legislation to address this problem and was encouraged to hear of the support of Colorado's Senators, "I'm absolutely delighted that we're making progress," he said, "and that our Colorado Senators are taking the lead in correcting this gross inequity."

## Next Month:

### Hawaii's Universal Access System

Many have asked about it. Look for a report from Executive Director Sandra L. Maloney in May.

### Americans with Disabilities Act

Its implications go far beyond what we were able to deal with in this issue (see page 139). Look for a more detailed report from CMS legal counsel in May.



## Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate  
with the firm of Montgomery Little  
Young Campbell and McGrew, PC.

*This column is not legal advice, but is for general  
information only. For help with specific problems,  
readers should consult an attorney.*

### Physicians Can be Employees of Medical Clinics

A 1991 IRS Private Letter Ruling found that physicians under contract with a hospital-owned medical clinic were employees and not independent contractors for federal employment tax purposes. The contract considered by the IRS includes the following provisions:

1. Unless approved by the clinic, the physician may only provide medical services to the patients at the clinic.
2. The clinic employs a general manager who determines the hours when the clinic is open for business.
3. The physician must agree to work business hours deemed reasonable by the clinic.
4. The clinic provides offices, facilities, equipment, personnel, supplies, utilities, accounting and legal services and other items reasonably required by the physician's practice.
5. The clinic purchases insurance necessary for the practice, including malpractice insurance.
6. The physician may receive as compensation a percentage of the gross charges of the clinic arising out of medical services directly performed by the physician or his designee, including direct patient care and office visits.
7. The physician is not paid for vacation time, sick leave, while attending continuing education or other leaves of absence.
8. The contract may be terminated at any time with or without cause, by the clinic or the physician.
9. The clinic has the authority to require compliance with its rules and regulations.
10. The physician does not assume any risk or loss of capital.

Although the ruling acknowledges that the clinic may not direct or control the day to day delivery of medical services to patients, the clinic has enough ability to direct and control physicians under contract to establish an employer-employee relationship for federal employment tax purposes.

Note that this Ruling is based upon the specific relationship between the clinic and physicians, as established

by the contracts under consideration. To determine whether other contracts establish employer-employee relationships, look at the terms of the contract and its similarity to the contract addressed here. *IRS Private Letter Ruling No. 91449001.*

### Medicare

Physicians are upset about Medicare restrictions on a beneficiary's right to privately contract with a physician for services that are covered under the Medicare Part B program. The government's position is that a beneficiary must "disenroll" from Part B of the Medicare program in order to enter into an agreement with a physician to pay for any needed medical services that are covered under the Medicare Part B program. The Medicare patient cannot decide on a per-service basis that a Medicare claim will not be filed and that the physician will be paid directly by the patient. Physicians who accept such payment are subject to monetary penalties or exclusion from the program.

A recent American Society of Medical Association Counsel (ASMAC) Memorandum outlines steps which have been taken in several states challenging the constitutionality of provisions of the Medicare law prohibiting physicians from billing, and patients from paying for certain services. None of the efforts have been successful. In North Carolina a group of physicians challenged various provisions of the Medicare program as interfering with a patient's right to contract with his or her physician. They lost. In Pennsylvania and New York challenges to state legislation mandating acceptance of assignment and a ban on balance billing failed.

One Medicare provision prohibits physicians from billing and patients from paying for an assistant cataract surgeon, unless the services have been approved by a PRO or a carrier prior to the surgery. In 1987, a class action suit was brought challenging the provision on the grounds that *inter alia*, patients have a constitutionally protected right to choose their treatment and to pay for it themselves if it is not covered by the Medicare Part B program. The U.S. Court of Appeals for the District of Columbia disagreed, stating that there is no "blanket right to obtain without any government interference every and any kind of treatment that might be available and that a physician might recommend." The Court reasoned that the patient could always choose to disenroll from the program, thus allowing the patient to choose his own treatment and protecting the physician from the sanctions otherwise imposed by the program.

In New Jersey, Dr. Copeland (an internist) and five of her Medicare patients filed suit against the Department of Health and Human Services (the usual defendant), alleging infringement of constitutional rights. That case is pending. The AMA plans to follow the *Copeland* case carefully.



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## Medical Society Takes Physician Complaints to Insurance Commissioner

The Colorado Medical Society has received numerous complaints regarding payment of Automobile No-Fault Benefits using the Workers' Compensation Relative Value Schedule. The following is a response to a letter written by CMS to the Division of Insurance:

*State of Colorado  
Department of Regulatory Agencies  
Division of Insurance  
Joanne Hill, Commissioner of Insurance*

**ISSUE:** THE Colorado Division of Insurance has received questions and complaints from automobile insurers and medical providers regarding the use of the Workers Compensation Relative Value Schedule (WCRVS) by auto insurers as the basis for reimbursement of medical claims submitted under personal injury protection (PIP) no-fault automobile insurance.

**DISCUSSION:** Regulation 74-19 requires that auto insurers use the WCRVS for the purpose of determining tort thresholds under the Colorado Auto Accident Reparations Act. This regulation was adopted under the authority of Section 10-4-714(1)(e) CRS, which requires the Division of Insurance to publish the average cost of specific types of services not less than once a year for the purposes of determining tort threshold. Regulation 74-19 does not address use of the WCRVS for any purposes other than determining tort threshold. Regulation 74-19 was amended in 1991 and language prohibiting the use of the WCRVS for purposes of determining the reasonableness of amounts claimed for personal injury protection benefits was removed. This change was made on the basis that the law does not authorize the Division of Insurance to adopt or exclude any particular reimbursement schedule in regard to determining payment of medical expenses that are reasonable and necessary for injuries under auto no-fault (Section 10-4-706(1)(b)).

It is important to note, however, that the WCRVS is 1) developed with input from providers and insurers; and 2) typically reviewed on an annual basis.\* Medical providers and insurers participate in updating the schedule. Public hearings are held by the Director of the Division of Workers' Compensation to obtain input from all interested parties. The WCRVS, therefore, represents some significant opinion about what is considered to be reasonable reimbursement to Colorado medical providers.

**DIVISION POSITION:** Auto insurers should use a valid means of determining what constitutes reasonable and necessary reimbursement for no-fault auto claims. The Division will neither prohibit nor adopt any method of determining what is reasonable or necessary and will not resolve disputes over reasonable and necessary charges under no-fault automobile insurance. Disputes over reasonable and necessary charges may be addressed either through the voluntary arbitration process or in the courts.

\* The current period is an exception, as the schedule is frozen until January 1993 per Senate Bill 91-218.

## Attend Your Precinct Caucus on April 14

The precinct caucus is the single most important political event of an election year. It is the place where you may impact the way your political party is headed and it is held in your own neighborhood! The date is Tuesday, April 14 from 7 - 9 pm — watch for flyers or other announcements where the caucus will be held. You may also contact your local party headquarters to determine the site of your caucus meeting.

Any person registered for two months with a political party and a resident of the precinct for 25 days prior to the caucus may attend and vote. Others may attend but may not vote.

The purpose of the caucus is to nominate the precinct committee members and delegates to the county assembly and/or convention. Merely attending a caucus does not obligate you in any way, but it does allow you an opportunity to state your political views and observe this important political meeting.

If you have never attended a caucus meeting, your CMS Government Relations staff will be happy to tell you what you might expect — just give Suzanne, Lorraine or Sue Ellen a call at 779-5455 or 1-800-654-5653, ext. 427.

## Physician Note:

The U.S. Occupational Safety and Health Administration on December 6, 1991, issued its amended Part 1910 of Title 29 of the Code of Federal Regulations concerning work areas handling bloodborne pathogens or other HIV-containing cell or tissue cultures, etc., effective March 6, 1992. An *Exposure Control Plan* must be in place by May 5, 1992.

We are unable to publish the entire Part 1910 of Title 29, but we'll be happy to take your requests for these printed regs; however you must request the regulations reprint by letter, addressed to **Colorado Medicine**, P.O. Box 17550, Denver, CO 80217-0550 ATTN: OSHA.

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

### World Congress on Healthcare

World Congress on Healthcare (live broadcast)  
from New York by satellite

April 8, 1991

Mike Dulligan (800) 879-3857

### Colorado Hospital Association

Americans with Disabilities Act: Are You Ready?  
Pueblo, Colorado

April 9, 1992

(303) 758-1630

### Hilltop Rehabilitation Hospital/UCHSC

Early Intervention of Industrial Injuries  
Snowmass Village, Colorado

April 9-11, 1992

(303) 244-6193

### Colorado Hospital Association

Continuous Quality Improvement for Hospitals  
Red Lion Hotel, Denver

May 1, 1992

(303) 758-1630

### Harvard Medical School

Mothers: Victimization, Stigma and Survival  
Children's Hospital, Boston, MA

April 22-24, 1992

(617) 432-1525

### Colorado Hospital Association

Americans with Disabilities Act: Are You Ready?  
Grand Junction, Colorado

April 6, 1992

(303) 758-1630

### American Academy of Neurology

Annual Meeting

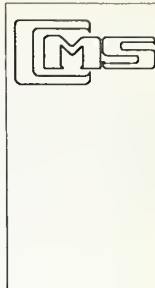
San Diego CA

May 3-9, 1992

(612) 623-8115







*Sandra L. Maloney  
Executive Director  
Colorado Medical Society*

## Saddling A Cow?

The CMS 1992 Interim Meeting is behind us. Attendance at this session was record breaking. Thanks to all of you who took time out of your busy schedules to attend. We considered thirty-six resolutions, a very high number for an Interim Meeting. The resolutions on HIV testing and health care reform generated lengthy discussion. Also, the resolution submitted by the Council on Ethical and Judicial Affairs regarding the reporting of incompetent or impaired physicians generated debate. A new issue was presented for consideration, the Americans with Disabilities Act (ADA). The ADA has far reaching implications for physician offices. Bob Montgomery, CMS legal counsel, and CMS staff will be preparing a packet of information which will be made available to all members.

I know that some people who attended the Interim were distraught over the fact that Mr. Terry Considine spoke at the General Membership Meeting on Saturday morning. I must tell you that we did indeed ask Senator Tim Wirth to speak and he declined. COMPAC has not endorsed Mr. Considine nor was there meant to be an implied endorsement. If any of you desire further information or clarification, please feel free to contact me directly.

Some of you have been concerned regarding Dr. Butler's statements on HIV testing. I can assure you that Corky would never do anything to harm CMS. He is a very concerned and caring individual who felt less than

positive after the Interim. The other night I ran across a quote from Mark Twain which reminds me of Doctor Butler: "It is not best that we should all think alike; it is difference of opinion which makes horse races." No, you may not always agree with him but he is willing to listen and to hear your concerns. For any of you to think that one person can set the policy for CMS, one must first remember that our policy is set by the House of Delegates. You must admit that this was one of the most exciting Interim Meetings we have had in recent memory. Give Corky credit for that. Our task now is not to fix the blame for the past, but to fix the course for the future.

Doctor Leigh Truitt (CMS President-Elect) has been busy planning for the Leadership Conference to be held July 10-12th, in Grand Junction. The theme for the conference will be "The Physician in the Year 2000." From my vantage point, I believe it is safe to say that a universal health program will be operational in Colorado in the year 2000. Some patient payment for medical care will be involved, to ensure that the patient takes personal responsibility for utilization and cost. Fees will be scheduled and determined through negotiations. Most physicians will be in group practice. There is not likely to be an excess of physicians, nor will they have more time, because with the inclusion of all citizens under a universal health care program, more care in total will be provided. I suspect that the serious professional liability problems will have diminished through

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*"It is not best that we  
should all think alike; it is  
difference of opinion which  
makes horse races."*

*Mark Twain*

# Executive Director's Report

(cont.)

*"I believe it is safe to say that a universal health program will be operational in Colorado in the year 2000."*

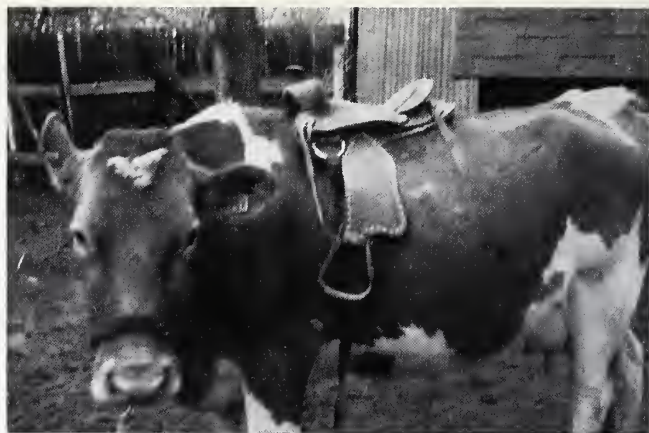
legislative reforms. Such reforms will take the form of placing caps on all monetary judgments and reducing the number of frivolous suits. These are but a few of the changes that will have occurred by the year 2000. CMS must evaluate its current activities and begin introducing new programs to respond to the changes. Since physicians will have less time and money to spend on volunteerism, CMS (more than ever) must spend time helping officers and others who want to be involved, so these physicians can positively influence the future of the profession. These are but a few of my thoughts about the future of medicine. Please join us at the Leadership Conference to share your ideas and shape the future of organized medicine in Colorado.

In a few short months, the "Little Prince" will no longer be on the CMS Board of Directors. He may soon be gone, but never forgotten. Yes, I am speaking of our own Doctor John Sbarbaro. John and I continue our lengthy "negotiation" sessions. Sometimes however, negotiating with John can be equated to saddling a cow; it takes an enormous amount of time and what's the point? (Gotcha, John!)

Dedicated physician leaders rise above the temptation to point fingers. They make it possible for CMS to survive and ultimately thrive. Doctors Butler, Truitt and Sbarbaro are such leaders.

Best regards to each of you and your families.

XXX♡



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# Ruminations

(def: to chew again what has been chewed slightly and swallowed; to REFLECT)

Organized medicine ten years ago

Reprinted from *The Denver Post*, Sept. 24, 1982.

## Health-Care Cost Revolt 'Lying in Wait' Says Lamm

### 'Corporate Medicine' Isn't Answer, Medical Society Told

by Sharon Sherman, *Denver Post*  
Capitol Bureau

Colorado Springs — A citizen revolt against rising hospital and health insurance costs is 'lying in wait out there,' Governor Dick Lamm told the Colorado Medical Society Thursday.

Lamm said government and the medical community need to work together to cure the 'disease' of escalating health-care costs, but he warned that "corporate medicine" isn't the answer.

The governor noted that angry taxpayers in California revolted by passing Proposition 13, and said a similar backlash to rising medical costs could occur in Colorado and elsewhere.

Lamm opened his speech with praise for the Society and its work on various laws. He also said twice, as he talked about rising health-care costs, that the doctors weren't to blame for the problem.

The governor said health-care facilities are being purchased by large corporations at an alarming rate.

While such consolidation may lower costs in some instances, Lamm said, the trend is making health care

an "economic entity (which is) moving away from community involvement."

Lamm warned that if hospital and physician corporations take over the health-care industry, small independent hospitals and independent doctors may be forced out of the system.

If that happens, he predicted, health programs for the poor may dwindle as the medical industry turns more and more to a concern for maximum profits and minimum losses.

The governor's Republican opponent, John Fuhr, later told *The Denver Post* in an interview that Lamm's attacks on corporate medicine don't offer any solutions to the problem of health-care costs.

Fuhr, a veterinarian, said he hadn't developed a specific plan of what he would do about that problem. But he said he would beef up the review process for health programs paid for by the government — such as Medicaid — so that those who truly need care are getting it and that waste is eliminated.

## Applications for Independent Medical Examiner (IME) Now Being Accepted

The Division of Workers' Compensation within the Colorado Department of Labor and Employment is taking applications from medical providers to serve as Independent Medical Examiners. Qualified applicants will be placed on the list of Independent Medical Examiners maintained by the Division and will be called, on a rotating basis with regard to specialty and location, to provide an unbiased medical opinion in workers' compensation cases.

As the Division of Workers' Compensation receives requests for independent medical examinations, it will make the arrangements for the exam and notify the appropriate parties. The fee for this examination is paid to the physician in advance. Within ten working days of the completion of the exam, the independent medical examiner will submit the resultant findings and recommendations to the Division.

Medical providers interested in conducting independent medical examinations are encouraged to call or write the Division of Workers' Compensation to obtain complete information and an application form. Inquiries should be directed to Sharon Elenburg, IME Coordinator, Medical Cost Containment Unit, Division of Workers' Compensation, 1120 Lincoln Street, Room 1403, Denver, CO 80203, (303) 764-4356.

# Caring About Health Care

An address by **Mark A. Levine, MD, Denver,**  
to Senior Days at the Capitol  
February 26, 1992

*"After all, we do call it medical care or health care - its very core and essence is caring."*

On a wall of my study at home, I have a copy of a picture that is very important to me. Perhaps you've seen it. It shows a mid-19th century physician sitting in a farm cottage at the bedside of a young child, bending toward the child with a look of great concern. Beside the physician are a few bottles on a table; probably containing the potions that he has used in an attempt to cure the ill child. In the background are the child's parents; the mother with her head down on her arm, crying in desperation, and the father with his arm gently on the mother's back, trying to comfort her, but staring with pleading, reverence, and trust toward the physician who is his family's only hope in this moment of crisis. A touching and very beautiful scene. It has always been one of my favorites, and I have kept it in front of me on the wall next to my desk for years. I hope that, like the physician in that picture, I have been able to provide a small measure of comfort, of guidance and of hope to the patients that I have treated in my 20 years of practice.

I do know that I have been able to provide far greater practical benefit to my patients than was any physician in the 19th century, for I have available to me the many wonderful tools of medicine that have been developed in the past 100 years. Think for a minute about all the advances that we have made; Penicillin and the other antibiotics; Imaging techniques - first the x-ray and now CT scans, MRIs, and ultrasound tests; surgery, once unfathomable and now so routine that almost any untoward result is a shock and a surprise; insulin for diabetes; cures for thyroid disease & ulcers; safe pregnancies; artificial kidneys; heart transplants. I could go on and on. Virtually

all of these advances have come about in the past 100 years. Today's Medicine is truly a modern miracle. No, we can't do everything yet, and we don't have all the answers, but certainly our development has been dramatic.

One small example of this is the improved medical care of Seniors. While there have been few dramatic breakthroughs in geriatrics, nevertheless, the growth of our understanding has been real. Today's physician is much more aware of the nuances of caring for older patients. And not just medical care. I believe that the medical profession is beginning to respond also to what I'll call the caring needs; needs that are social, psychological, and nutritional as well as medical - the subtle needs that are so important but so difficult to quantitate.

But it isn't easy for physicians to care for these more subtle needs. Today's health care environment has changed dramatically from what it was a few years ago. Our revered 19th century physician had little practical to offer, but he was free to offer whatever he could, and his patients were grateful that at least he tried. He cared. Now, isn't that an interesting word. He CARED. He might not have been able to do much more than that, but he did care. Sometimes it is easy to forget that even to this day, the essential nature of medicine is caring. After all, we do call it medical care or health care - its very core and essence is caring.

While today's physician can care about his patients, he had better be able to prove that his care makes a practical difference. In the 20th century we have become very outcome oriented. We demand proof and accountability for our care. Just holding hands and looking concerned is not sufficient





today. It might be essential, but it is not sufficient.

We are all conscious of the ever-rising cost of health care, and increasingly concerned with our ability to afford it. This concern is real and it is justified. We can provide so much today; but there appears to be no limit. As government and insurers, businesses and individuals all look for means of limiting their expenditures for health care, we physicians are an easy target. "Too many tests!," they cry. "Too much unnecessary care!" We doctors are being accused of performing unproven procedures, of providing unneeded care. As a result there are now many attempts to regulate us. There are ever more forms to fill out, permissions to obtain and suspicious people looking over our shoulders. If that peaceful scene in the cottage were to be painted today, the farmhouse would be crowded with lawyers, businessmen, insurers and regulators making sure that the doctor was doing everything just right.

I can't say that these people are wrong either. Inappropriate medical care is reprehensible. We physicians should be held accountable for what we

do. Society has a right to know what it is getting when it pays for medical care, and we physicians have a responsibility to justify what we do.

But what worries me is that we are in danger of turning medicine from the noble and esteemed profession that it has been and, thankfully, still is, into a dry, detached and sterile system dispens-

ing procedures by rote and by formula. If, God forbid, that should happen, we would have come a long way from the doctor in the picture who could dispense little in the way of proven medicine but lots of care; we would have a new generation of "provider" capable of truly excellent technical medicine, but not the CARING that has been the hallmark of the medical profession since time immemorial.

American medicine is in a state of crisis now. There are fewer young people than ever interested in becoming "primary" physicians, the ones that provide the caring. Fewer physicians than ever are practicing in rural and inner city areas. More and more doctors are attracted to the more technical, procedure-oriented specialties. That seems to be where they think the action is. And no wonder, for the rewards of practice for the caring primary physician are rapidly diminishing. There is less and less medical CARE being given at a time when we are capable of delivering an excellence of medicine beyond yesterday's wildest dreams.

Senior citizens are perhaps America's most sophisticated people involved in health care today. The medical profession owes much to Senior groups who have demanded, and have obtained, advance directives, personal choice and individual responsibility in health care. How many Seniors today are looking only for technical excellence in their health care? I trust that Seniors, perhaps more than any other group, value the presence of a caring, personally responsive advocate in this enormously confusing medical world. If this is true, then please help us to avoid evolving the American Health Care system into an impersonal, distant system of technical excellence. The medical profession needs your voice now as we have never needed it before. Please help America to understand what is needed in any new system of medical care.

We have all heard the proposals for reforming the Health Care System. None of them is perfect. All have their strengths and all have their weaknesses. I have no way of knowing which of them will be enacted, but we all know that something will change. We cannot continue with our current system of health care. There are too many Americans who are not included. We cannot afford its costs, and, I also submit, we cannot afford its increasing emphasis on the technical, impersonal delivery of medicine and procedures. We must find a way to insure that "care" remains in the phrase "medical care" and to maintain our focus on the true and revered meaning of medicine as THE CARING PROFESSION. In so doing we may be able to truly reform health care to the benefit of all of us.



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# Rural Health: CARING for the country

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By Michael P. Thompson  
Assistant Managing Editor  
Colorado Medicine Magazine

Those involved in practicing medicine in rural areas speak most fondly of the benefits of small town practice and country living. Yet they also speak sadly of the drawbacks and restrictions of practicing away from major population centers. The Colorado Medical Society has continued to focus attention on this tension in an effort to make rural health care even more rewarding than it already is. If more physicians are to be motivated to practice in such areas, it holds that they must first be sold on the idea, whether in medical school or in practice elsewhere. An upcoming major national conference goes a long way in that direction.

The National Rural Health Association will hold its fifteenth Annual Conference on Rural Health in Washington, DC May 6-9, 1992. It will address rural health issues and the educational needs of people who practice and work in rural areas, as well as others with an interest in rural health.

The conference will be designed to develop practice skills and techniques in health services administration, organization and research; present practical clinical sessions of interest to rural health providers; showcase current policy issues affecting rural health services; report the results of research applicable to rural health service administrators and providers; and assist in the improvement of personal growth and development skills.

In addition to the main sessions, there will also be optional activities and special interest meetings. Senator John D. Rockefeller IV of West Virginia will deliver the Terry B. Reilly Memorial Lecture on Wednesday, May 6. Noted author and lecturer Emily Friedman will moderate a panel discussion on May 7 entitled, *Rural Concerns and Health Care Reform: Is Anyone Listening?*

There will also be a General Session on Friday, put on by Educational Playmakers, Inc., a group of performers, discussion leaders and writers dedicated to using their professions for education and training purposes. It is called *No System*, in recognition of the fact that there is no system for rural health care in the United States. Political columnist Molly Ivins, a three time Pulitzer Prize finalist, will present *Politics and Other Insanities* on the final day of the conference.

A large number of presentations and breakout sessions is scheduled on a variety of topics including HIV and rural health care, recent HCFA payment changes, electronic networking, Workers' Compensation, advocacy, agricultural medicine, rural hospitals, mid-level providers and a host of others. There will also be papers presented at many sessions on topics related to rural health care.

*Registration Deadline is April 24. Call (816) 756-3140 for a conference brochure and registration form.*

# "Rural Lifestyles"

## Helping Students Care About Health

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*How do you get urban students interested in rural practice? Maybe you just let them experience the benefits of rural life and health care....*

"Rural Lifestyles" is a program for college students who are interested in the health care professions. It was designed and implemented by Mary Jean Berg, MD and the Arkansas Valley Regional Medical Center as a pilot program to help urban students get a feel for the value of a rural practice.

### The Student Experience

Between June and August 1991, six students from urban areas each spent two weeks participating in an educational program which exposed them to the opportunities in health careers available in rural communities and gave them a first hand experience of the benefits of rural living.

Each student lived with a local family and participated in family activities during the stay. In addition, several different experiences with health professionals were available, such as spending time in the hospital, the local community clinic, the area health department and in a physician's office. Each student was required to record this experience in writing and on film. A small grant provided by the Colorado Trust provided a \$150 per week stipend for the students.

### A Successful Program

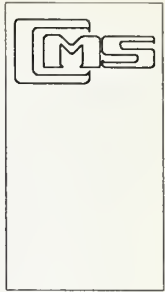
Questionnaires completed after the program by all participants indicated that the program was successful. Dr. Berg, a Family Practitioner from Ordway, says that if the program were replicated in other rural communities in Colorado, the result could be a significant number of participants who would be comfortable with exploring career opportunities in rural areas after finishing their education.

According to Dr. Berg, "three ingredients are necessary for success — a small amount of money, an enthusiastic program director and a competent secretary to keep students and educational persons on track." In fact, Dr. Berg credits her daughter, Jennifer Berg, who acted as coordinator for the project, as essential for its success. Dr. Berg has compiled all the forms and letters used to implement this program and has agreed to make them available to local hospitals or medical societies for replication.

### More Details

For more information you may contact Ellen Stein or Marilyn Barton at the Colorado Medical Society (303) 779-5455 or 1-800-654-5653.





Alan D. Rapp, MD, Chairman  
CMS Council on Legislation  
with  
Sue Ellen Quam, Director  
Department of Government Relations  
and  
Lorraine Koehn  
Program Manager/Lobbyist

Legislative sessions are always a challenge for physicians, their spouses, patients and legislators. This year our state has experienced more than its fair share of stress due to economic worries regarding school finance, expansion of recipients to the medicaid program, redistricting, controversial legislation, etc. It has challenged and sometimes tried the patience of all parties in this process.

Many good things have happened this year because of our legislative involvement. We very much appreciate your actions on bills which have been of major concern to health care workers and patients.

HB 92-1010, (by Representative **David Owen** and Senator **Bonnie Allison**) "Concerning the Practice of Midwifery, and in Connection Therewith, Providing for the Registration of Midwives Within the Division of Registrations" was defeated in the Senate Judiciary Committee on 2-26-92 by a 4-4 vote. The lay midwives fervently believe that they can and should be sanctioned to participate in home births. **Mary Jo Jacobs, M.D.** testified on behalf of CMS. We have highlighted a few of the reasons why CMS disagreed and consequently opposed the bill.

- \* The bill would have created a tiered level of care in which the persons most at risk for high infant morbidity would be more likely to be the recipients of the service. It would not aid in lowering infant mortality in the ethnic and cultural groups who have traditionally used this type of service but who unquestionably demonstrate our highest levels of infant mortality.
- \* The scope of practice was not delineated, except that midwives could provide "normal" (not defined) pregnancy, labor and post-partum care and could not prescribe drugs or perform surgery. The bill would have allowed lay midwives to diagnose whether the mother is high risk or low risk.
- \* No matter how normal a pregnancy may seem, circumstances can arise at the last minute (prolapsed umbilical cord, nuchal cord, placenta previa, etc.) where emergency resuscitation, specialized equipment and expert care must be available during a critical few minutes.
- \* The bill did not provide adequate safeguards for the health and safety of mother and infant. Even in licensed birthing centers where physicians evaluate risk of delivery, approximately 1 in 8 of all "low risk" pregnancies convert to high risk at or near delivery.

*"Emotions ran high."*

Emotions ran high on this bill as it was presented by some that it was a turf issue and not an issue of safety for mother and child. Senator **Bonnie Allison**, cosponsor, accused CMS of "cruel and unusual treatment" of her. We have heard that a few physicians, at a meeting sponsored by a component society, hotly debated the merits of the bill with her. We regret that this interaction was characterized as being condoned or sponsored by CMS.

We are pleased to express our support for **Dr. Patricia A. Nolan** as our new State Health Department Director. CMS was invited to participate in the review of the qualifications of the top candidates for this important position. We spoke with key people in Arizona who knew the quality of her work and she was highly recommended to us. **Ron Tegtmeier, M.D.** was our representative to review the top three candidates for this position. **Harrison G. Butler III, M.D.** indicated our support to the Senate HEWI Committee. Dr. Nolan was unanimously endorsed by the HEWI Committee and will now talk with the Senate Agriculture Committee before her appointment is confirmed by the Senate.

**George Thomasson, M.D.** has been of great assistance to us in providing information to the Joint Budget Committee on funding issues. **Bob McCartney, M.D.** has provided excellent information to our CMS staff regarding Medicaid proposals by the Joint Budget Committee and Social Services. **Don Parsons, M.D.** testified for us on SB 92-120, by Senator **Pascoe** and Representative **Pankey**, regarding a pilot program for the coordinated delivery of supportive services through family development centers.

The Council on Legislation, and CMS staff, have responded to many of the resolutions passed at the last Annual meeting. A recap of some of the resolutions pertaining to legislation are as follows:

#### RES-7-A Family Violence

and be it further RESOLVED, that, recognizing that state funded alcohol, drug and local health department treatment and prevention programs are essential resources to physicians who must deal with domestic violence issues, the Colorado Medical Society

urge the Governor to immediately rescind his recently proposed funding cuts to alcohol, drug and local health department treatment and prevention programs.

**Comment:** CMS immediately responded to the proposed cuts by sending a summary of our concerns to the Governor. We outlined the seriousness of the budget cuts and their ramifications to health care delivery in our October and November issues of *Colorado Medicine*. We urged our membership to contact both the Governor and members of the legislature to express our support for a cigarette tax increase. These new funds were to be used to offset budget deficits. We encouraged CMS members to explain the ramifications of these proposed cuts on the medically indigent and to other citizens, particularly within our rural communities. We worked with family physicians to help restore their \$1.2 million cut in the family residency program. **Dr. John Muth** supplied excellent information to us regarding the impact of these cuts.

RES-10-P, *Continued Funding for Emergency Medical Services in Colorado*: RESOLVED, that the Colorado Medical Society actively supports legislation which 1) continues the funding for the Emergency Medical Services Account, 2) continues to fund such account from the highway users tax fund, 3) determines that the appropriation of such monies goes toward grants to emergency medical services providers pursuant to the EMS grant program, planning and coordination of county EMS services, and the development and improvement of the statewide EMS system, and 4) allocates a portion of the funding to obtain the services of an in-house medical director for the Emergency Medical Service (EMS) Division.

**Comment:** We have spent a great deal of time working with Senator **Claire Traylor**, the American College of Emergency Physicians, **Larry McNatt** from the State Department of Health (EMS Division), and others to secure passage of SB 92-78. It is scheduled for second reading on the floor of the House within the week. **Catherine Mueller, M.D.** provided testimony on behalf of CMS and

ACEP.

#### Res-11-P, *Pre-Hospital Care Physician Advisors in Rural Colorado*:

RESOLVED, That the Colorado Medical Society work with the EMS Division of the Colorado Department of Health to develop feasible options for providing such physician advisor coverage to areas in need, etc.

**Comment:** While this resolution was not specifically adopted by the Reference Committee on Legislation/Professional Education it should be noted that HB 92-1081 was introduced to eliminate the requirement for a physician advisor for emergency medical technicians, etc. CMS opposed this legislation. Drs. **Stewart Greisman** and **John Sbarbaro** testified on behalf of CMS. The bill was defeated in the House HEWI Committee. We have agreed to meet with all interested parties and try to forge a workable compromise with Weld county participants.

#### RES-19-P, *Mid-level Providers in Rural Colorado*

**Caveat:** The Practitioners should be advised that the Board of Medical Examiners has a rule, which has the force of law, that there is a presumption that: 1. The supervising physician shall be routinely present where the non-physician provider practices, and 2. The supervising physician cannot adequately supervise more than two non-physician health care providers. The rule also provides that the supervising physician must review the work of non-physician providers not less than every two working days.

**Comment:** While this resolution was referred back for further study, HB 92-1091- "Concerning the Authority of Physician Assistants," was introduced by Representative **Ken Chlouber** at the request of the Colorado Hospital Association. The bill, as introduced, permitted physician assistants to provide care without a physician being on the hospital premises to supervise the physician assistant when delegated duties were being carried out. CMS worked with the Board of Medical Examiners to oppose the initial draft of the bill. It would have permitted that a physician never personally observe the physician assistant working in a clinical setting. The physician could also have



been geographically located in another area than where the physician assistant treats patients, etc. The bill was rewritten to give the Board of Medical Examiners the authority necessary to adequately supervise physician assistants and still allow for a physician assistant to provide some care based on written protocols and verbal and written physician orders minus on-site supervision. The status of the bill is questionable at this writing. It will be heard on second reading in the Senate within the next several days.

RES-22-A, *Educational Program on Advanced Directives*:

RESOLVED, that the Colorado Medical Society in collaboration with other appropriate organizations support an educational program for its members and patients regarding our current and proposed state laws regarding the federal statutory requirement, effective 12/1/91, that directs all institutions receiving Medicare or Medicaid money to advise all patients on admission to the facility about state laws concerning advance directives.

**Comment:** In response to the OBRA regulations, a coordinated effort by a state-wide coalition (including Colorado Medical Society and Colorado Hospital Association) developed a booklet which physicians can make available to their patients. These booklets, "Your Right to Make Health Care Decisions," are available for \$18.00 per 100 plus UPS Charges for delivery outside the Metro Denver area. This information was reprinted in our December issue of *Colorado Medicine* Magazine. In addition to these efforts, CMS sponsored a morning workshop on "Advance Directives: The Physician's Role In Informing Patients" on December 11, 1991 with **Frederick Abrams, M.D.** conducting the presentation.

RES-27-P, *Prevention of Insurance Fraud in Relation to Motor Vehicle Accidents*:

RESOLVED, that the Legislature of the State of Colorado undertake an in depth analysis of laws covering insurance fraud, and be it further

RESOLVED, that the Legislature of the State of Colorado enact additional legislation, if necessary, to provide for more active prosecution of

those who may have committed insurance fraud in relation to motor vehicle accidents, and be it further

RESOLVED, that the State Attorney General's office be directed to actively seek out and prosecute to the maximum extent of the law all health care providers, attorneys, insurers and injured parties who may have committed insurance fraud in relation to motor vehicle accidents insurance coverage.

**Comment:** Ms. Joanne Hill, Insurance Commissioner of the State of Colorado conducted hearings this fall on insurance abuse and fraud. CMS participated in this review by submitting written testimony and providing additional oral testimony by **Brent Lovejoy, D.O.**

RES—28-P - *Religious Exemption to Child Medical Neglect Law*:

RESOLVED, that the Colorado Medical Society, through its legislative liaisons, shall work with appropriate entities in order to build a coalition to investigate means of substantial alteration of Section 19-3-103 and Section 18-6-401 of the Colorado Revised Statutes, to remove barriers to appropriate medical care for children and dependents.

**Comment:** SB 177 - "Concerning Circumstances for Providing Medical Interventions in Child Abuse or Neglect Proceedings" has been introduced by Senator Dottie Wham and Representative Betty Swenson. The proposal authorizes the court to order medical evaluations in child abuse or neglect proceedings, including cases involving spiritual healing. The bill as introduced removed the presumption regarding recognized methods of religious healing. The bill was later amended to reinstate the presumption but now states that the religious rights of a parent, guardian, or legal custodian shall not limit the access of a child to medical care in a life-threatening situation or when the condition will result in serious handicap or disability. In order to make a determination as whether the child is in a life threatening situation or when the condition will result in serious handicap or disability, the court may order a medical evaluation of the child. If the court determines, on the basis of any relevant evidence before it, including the medical evaluation

ordered, that the child is in a life threatening situation or when the condition will result in serious handicap or disability, the court may order that medical treatment be provided for the child. **Carole Jenny, M.D.** and **James Shira, M.D.** testified on behalf of CMS in support of this legislation. It is now scheduled to be heard on the House floor and we will continue to lobby for its passage.

RES-31-P, *Proposed Amendment to Safety Belt Law*:

RESOLVED, that the Colorado Medical Society goes on record as fully supporting an amendment to the Colorado Safety Belt Law, CRS 42-2-236, Common Code 960, to allow primary enforcement to the statute, and/or to raise the fine for a violation of the statute to be commensurate with other traffic violations of a like class.

**Comment:** CMS actively worked on the passage of this legislation but it was defeated. We issued an "Alert" requesting assistance from our membership, highlighted the primary points in support of the legislation in *Colorado Medicine*, targeted "Key Contacts" for assistance, lobbied our assigned Senate members and had **Harrison G. Butler III, M.D.** testify in support of this legislation. Senator Sally Hopper and many other groups worked very hard for passage of this bill. Their efforts were very much appreciated.

RES-42-A, *Equitable Reimbursement for Young Physicians*:

RESOLVED, that the Colorado Medical Society encourages the American Medical Association to continue support of H.R. 1898, a bill to amend the Social Security Act to repeal reduced Medicare reimbursement for new physicians, as a top rank legislative priority, and be it further

RESOLVED, that CMS join the AMA in actively seeking co-sponsors for H.R. 1898 and introduction and co-sponsorship of a Senate companion bill.

**Comment:** Senators McCain, Wirth, Brown, Grassley, Nickels and Chafee have just introduced a bill which would eliminate discrimination in Medicare reimbursement practices against those physicians identified by the Medicare Program as "new physicians." Representative Ed Towns

*For more information, contact the CMS Department of Government Relations at (303) 779-5455 or 1-800-654-5653.*

introduced similar legislation, H.R. 1898, last year. Their proposal will repeal the inequitable provision of existing law where Medicare payment to so called "new physicians" in their first four years of practice is reduced. With some limited exceptions, the law reduces the payment base or allowed amount by 20% in the physician's first year of practice, 15% in the second year, 10% in the third year, and 5% in the fourth year. Their bill would repeal this provision of the law and would have no budgetary impact. We are very appreciative of their sponsorship and will work with them on securing passage of this legislation. **Rob Bogin, M.D.** has worked diligently on this issue and deserves our thanks.

*RES-43-P - Restricting Communication Between Physicians and Patients:*

RESOLVED, that CMS strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient, and be it further

RESOLVED, that CMS urge the American Medical Association to work with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that, 1) prevent physicians from freely discussing with or providing information to patients about medical care and procedures, or 2) interfere with the

physician-patient relationship.

**Comment:** The AMA worked very hard on this issue but was not able to sustain the votes necessary to stop this legislation. CMS leadership and staff also discussed this issue with our congressional delegation last fall.

*RES-78-A, Review of Third Party Benefit Plans/Denial of Services Based on Pre-Existing Conditions*

RESOLVED, that CMS seek legislation to require all health insurance companies to utilize a STATE WIDE rating system when establishing rates for health insurance policies, and be it further

RESOLVED, that CMS address these concerns while not losing view of issues including access of care, the medically indigent and evaluations of future universal access proposals.

**Comment:** CMS staff has not had enough time to do the research necessary to propose such legislation.

*RES-23-A, Auxiliary Voting Privileges on the CMS Council on Legislation:* RESOLVED, that the Colorado Medical Society Auxiliary Legislation Chairman be considered a member of the Colorado Medical Society Council on Legislation and the voting privileges also be extended to said auxiliary chairman.

**Comment:** Ms. Patty Brown is serving as the Legislative Chair of the Colorado Medical Society Auxiliary and is their member on the COL.





The following resolution was adopted at the 1992 Interim Meeting of the Colorado Medical Society House of Delegates. Members of the COMPAC Board of Directors encourage you to contact the COMPAC staff at 779-5455 or 1-800-654-5653 to determine if you have joined COMPAC in 1992.

Introduced by: COMPAC Board of Directors

Subject: Membership of the Colorado Medical Society  
Leadership in COMPAC/AMPAC

Referred to: Reference Committee on Board of Directors/Constitution & Bylaws/Credentials

WHEREAS, the future of medicine in Colorado and in the nation is in the hands of the elected state and federal representatives, and

WHEREAS, Colorado will be electing one U.S. Senator, six U.S. Congressman, half of the State Senate and 65 members of the state House of Representatives in the November elections, and

WHEREAS, many of the state officials will be running in newly-formed districts because of state reapportionment, and

WHEREAS, the average cost of a 1990 successful Senate campaign was \$38,539 and the average cost of gaining a seat in the Colorado House of Representatives was \$30,184, and

WHEREAS, few, if any, of the candidates have the personal funds to finance a successful campaign, and

WHEREAS, COMPAC must have funds available to contribute to candidates deserving of the support of the medical community, and

WHEREAS, every physician should become a member of COMPAC/AMPAC, our state and AMA political action committees, and

WHEREAS, the leadership of the Colorado Medical Society which includes the Executive Committee, Councils, Committees, and the members of the House of Delegates should set the example for membership and join COMPAC/AMPAC in carrying out their duties, therefore be it

RESOLVED, that Colorado Medical Society leadership shall be urged to join COMPAC/AMPAC at any of the two levels of membership (i.e. Active - \$50; Sustainer - \$99); and be it further

RESOLVED, that all members of the Colorado Medical Society be encouraged to join.

# T

# ime for the 1992 Directory

*If you want to be listed accurately in the 1992 Directory, please take note.*

Each year, the Colorado Medical Society publishes a Directory of its physician members. Each year some physicians are disappointed because they are listed incorrectly or not at all. Here is your chance to make sure that doesn't happen to you.

You, as a member physician, are our only authoritative source of the information that goes in the Directory. That is why, before we publish anything, we send out these cards, listing the information as we have it. We ask you to make any corrections, sign the card and return it.

Below, you will find an explana-

tion of the format of the card. If an item on your card is blank, that means either we do not have the information or you have requested it to be unlisted. Make any updates or corrections right on the card and return it to us. Don't forget to sign the card.

If you have not yet received your card, please notify the CMS office at once at (303) 779-5455 or 1-800-654-5653, extension 411. Of course, you may inform us of a change of address at any time, but if you want it listed in the Directory for the coming year, we need to know right away. Thank you for your cooperation.

YOUR NAME: Please check spelling.

We need to know whether you are retired. If we know you are, this question will read, "Are you still retired from practice?" You may update this status merely by checking yes or no.

YOUR CMS ID NUMBER

Check your office address and telephone number to be certain they are correct. Also, please note whether you would like to have them listed in the Directory.

Mary L Jones, DO  
Office Address:  
10643 Ridgeway Rd  
Alamosa  
CO 81101 (719) 845-0951  
Home Address:  
93 Fairway Dr  
Del Norte  
CO 81132 (719) 846-0211  
HAVE YOU RETIRED FROM PRACTICE? \_\_YES \_\_NO  
Specialties: FAMILY PRACTICE

0000

You may list up to five specialties in this area. Make any corrections on the card

This will be your listing in the 1992 Physician's Directory. Please return this card with or without corrections by 4/3/92.

Please sign: \_\_\_\_\_

Check your home address and telephone number to be certain they are correct. Also, please note whether you would like to have them listed in the Directory or unlisted.

Please note the deadline, correct, sign and return the card in time for us to update your records for the 1992 Directory. If we do not hear from you, we can only assume that the information on the card is correct.





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Ext. 301





# Colorado Registry for Children with Special Needs

*Sharon Keefer, Director*

*Colorado Registry for Children with Special Needs*

*For children under three diagnosed as having a birth defect, developmental disability or risk factor for developmental delay.*

The Colorado Registry for Children with Special Needs (CRCSN) appreciates physicians' assistance in efforts to identify children with special needs.

CRCSN is a centralized, statewide identification system for young children with birth defects and developmental disabilities. Formation of the CRCSN began in 1988 with the goal of creating a database for epidemiologic investigations as well as prevention programs.

Specifically, the purpose of the CRCSN are to: (1) permit epidemiologic monitoring and preventive intervention; (2) provide accurate, aggregate statistics and an unduplicated count of children with special needs for program planning; (3) help prevent secondary disabilities by connecting children and families with services; and (4) provide a database to help researchers better understand causes and prevent future birth defects and developmental disabilities.

## Physician Reporting

Physicians and other health care providers are welcome to identify children to CRCSN. Registration forms are available, or physicians may call the Health Department's 24-hour disease reporting phone number, 1-800-866-2759. Because physician reporting is voluntary (except for Fetal Alcohol

Syndrome which physicians are required to report), physicians may inform CRCSN if they prefer families not be contacted for a home visit and referral to services based on their report.

## Eligibility and Data Sources

To be included in the Registry, a child must be a Colorado resident under age three and diagnosed as having a birth defect, developmental disability or risk factor for developmental delay. Specific eligibility criteria are listed in Table 1. Children meeting these criteria are identified from automated linkage of information from the multiple sources shown in Figure 1.

## Confidentiality.

The database has been designed to protect the confidentiality of reports to the Registry and the privacy of registered children and their families. Data included in the CRCSN include identifying information such as name and address, plus diagnoses and medical procedures, reporting sources and birth certificate information (variables such as maternal age and education, birth weight and parents' occupations). Personal identifiers are necessary to ensure unduplicated counts



**Table 1**

## Colorado Registry for Children with Special Needs

### Eligibility Criteria

1. Resident of Colorado
2. Aged birth to 3 years
3. Diagnosed as having one of the following conditions

#### Established Medical Diagnoses

Major Congenital Anomalies and Chromosomal Abnormalities

#### Congenital (Perinatal) Infections

Congenital syphilis  
Congenital rubella  
Cytomegalovirus  
Toxoplasmosis/Herpes simplex  
Neonatal hepatitis

#### Sensory Impairments

Hearing loss  
Blindness and low vision

#### Other Disabilities

Specific delays in development  
Mental retardation  
Infantile cerebral palsy

#### Genetic and Endocrine/Metabolic Diseases

Hypothyroidism  
Disorders of amino acid transport and metabolism  
Disorders of carbohydrate transport and metabolism  
Disorders of carbohydrate transport and metabolism  
Lipidoses  
Disorders of copper metabolism  
Cystic fibrosis  
Other disorders of purine and pyrimidine metabolism  
Mucopolysaccharidosis  
Sickle cell anemia

#### Medical Risk Factors for Delay

##### Infections

Encephalitis  
Meningitis

##### Injuries

Head  
Spinal cord

##### Other Diagnoses

Amniotic bands  
Cerebral cysts  
Cerebral lipidoses  
Child maltreatment syndrome  
Chorioretinitis  
Convulsions/seizures  
Drug withdrawal syndrome in the newborn  
Failure to thrive  
Familial degenerative CNS disease  
Infantile spasms  
Muscular dystrophies  
Noxious influences affecting fetus (includes Fetal Alcohol Syndrome)  
Renal tubular acidosis  
Retinal degeneration  
Werdnig-Hoffman syndrome  
Intracranial hemorrhage

##### Other Conditions

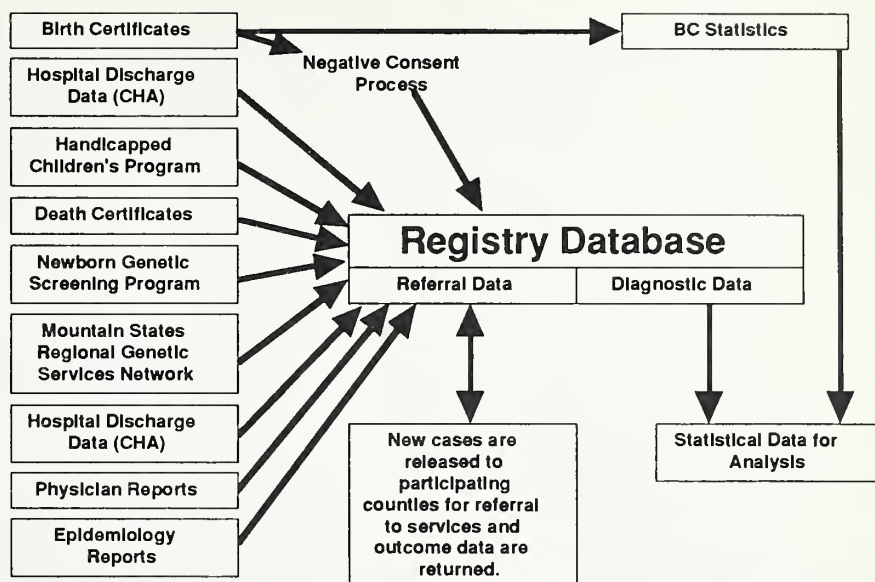
Birth weight less than 1500 grams  
Prematurity less than 32 weeks gestation  
APGAR 3 or less at 5 minutes  
Meconium aspiration syndrome  
Birth trauma

##### Environmental Risk Factors for Delay

Maternal age 15 years or less  
Maternal education — less than 12 years and no prenatal visits

**Figure 1**

### Colorado Registry for Children with Special Needs Data Flow Diagram

**Table 2**

### Colorado Registry for Children with Special Needs Number of Children Registered by Eligibility Category Preliminary Data for 1989 and 1990 as of March 1, 1992

	<u>Number</u>	<u>Percent of Births</u>
TOTAL BIRTHS	106,188	100%
TOTAL REGISTERED CHILDREN	11,595	11%
		<u>Percent of Registered Children</u>
<b>ELIGIBILITY CATEGORY</b>		
Established Medical Diagnoses		
Congenital Anomalies	6,914	60%
Congenital (Perinatal) Infections	58	1%
Sensory Impairments	252	2%
Other Disabilities	230	2%
Genetic and Endocrine, Metabolic Diseases	134	1%
Medical Risk Factors for Delay		
Infections	178	2%
Injuries	181	2%
Other Diagnoses	1,049	9%
Other Conditions	3,297	28%
Environmental Risk Factors for Delay		
Maternal Age 15 Years or Less	762	7%
Maternal Education Less than 12 Years AND no prenatal visits	552	5%

Numbers and percents of children by eligibility categories do not sum to total:  
15% of children qualify in more than one category.

See Table 1 for specific conditions included in eligibility categories.



*"About 6,000 children (11% of births) per birth-year are being registered. ...Fifteen hundred registered children have been referred from CRCSN."*

of children. However, the personal identifiers can only be linked to diagnoses and other data through a unique identifying number. The Registry is a secondary holder of data, with a stricter confidentiality protocol than many of the original sources.

### **Preliminary Results**

About 6,000 children (11% of births) per birth-year are being registered. Numbers of children registered by eligibility category are shown in Table 2. Sixty percent registered have congenital anomalies, 41% have medical risk factors for developmental delay and 12% have the selected environmental risk factors for delay; 15% qualify in multiple eligibility categories.

The first comprehensive data report from CRCSN is scheduled for distribution in Fall, 1992. Requests for specific statistics from the CRCSN are welcome any time.

### **Disability Prevention— The CRCSN Notification and Referral Program**

The CRCSN includes a service referral component to meet the goal of preventing secondary disabilities. Through this program, families of children identified by the CRCSN are

connected with services available in their home community.

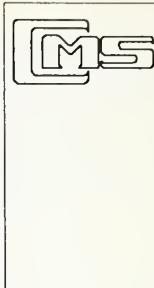
In January 1990, the CRCSN began pilot testing the notification and referral program through local health agencies in 14 counties. As representatives of the CRCSN, the local health agents (usually public health nurses) visit families and refer them to services such as developmental screening and assessment available through local Child Find programs. The local representatives observe state confidentiality provisions and obtain a signed release from parents before sharing any personal identifying information with service providers. Also, if parents wish, their child's physician is notified of the referral to such services.

Twelve counties are currently participating in the CRCSN referral program; programs in an additional eight counties are starting this year. Fifteen hundred registered children have been referred from CRCSN to local representatives; about half of the families are referred on into locally available services.

### **For More Information**

For more information about the Colorado Registry for Children with Special Needs, or to request registration forms, please contact Sharon Keefer, CRCSN Program Director at (303) 331-8353.





Edie K. Register, Director  
Health Care Financing

## Visit Codes Revisited

Grant E. Steffen, MD  
Medical Director, Medicare Part B  
Blue Cross/Blue Shield of Colorado

Early in February, Dee Cole, Cindy Hoskins and I conducted our 26th Evaluation and Management Codes seminars. These all took place in the Denver Metro area. Members of the CMS staff presented the same material throughout the rest of the state, a demanding task for which I want to acknowledge them. By this writing, physicians will have had more than six weeks experience with the new "visit codes" and may have more questions now than before the presentations. I would like to address one question that was asked many times and still may be causing confusion, the question of time. I will also describe how we will evaluate physicians' use of these codes.

On page three of the 1992 CPT (Current Procedural Terminology—if you don't have one, buy one—and read the guidelines) you will find listed the seven elements that are used to define each of the Evaluation and Management Service codes. Recall that the first three (history, exam, medical decision making) are by far the most important. The next three (counseling coordination of care and the nature of the presenting problem) are less important and, in fact, may play no role in defining a code. The seventh, TIME, is the problem. The time that you spend conducting the office, hospital or home visit is NOT the element that you should use when matching a code to what you did. That matching is done almost always by

selecting the proper level of intensity of the three primary elements.

But there's one exception. When counseling (please review page two in the CPT) takes up more than half the time (defined on page four), then you should take the total time spent and match that with the time given at the end of each code description. Again, while most code descriptions (ER codes are an exception) give a typical time, that is only there to give the physician an idea of what the people who developed these codes believed was an average. Thus, if you develop the levels of intensity of the history, exam and medical decision making that characterize a code, but take less time than indicated, (you're efficient!) you should still bill that code. Conversely, if you take more time than indicated to develop that code, you should not up code. Only when counseling makes up the majority of the time is time the deciding element.

HCFA (the federal Health Care Financing Administration) has developed a review program to help the physician with these new visit codes. The program has two parts, the first of which is called Early Claims Review. Each week, we will select up to 25 claims that list a new visit code. We will call the physicians concerned and ask them to send the records for which the visit codes were billed. I recognize that this is an inconvenience, particu-

*"Current Procedural Terminology—if you don't have one, buy one—and read the guidelines."*

*"To live is to change, and to live well is to change often."*

larly with hospital records, but would ask your cooperation.

When we get the records, we will analyze them and decide whether or not your documentation justifies the code you billed. We will let you know by letter if we believed that you billed too high, too low or just about right. Please understand that this review has education as its goal. We will not ask for money back if we believe you billed too high, nor send you money (no surprise here!) if we believe you billed too low. The goal, again, is to help you use the new visit codes correctly. This review is in process and will end, we are told, around July 1, 1992.

The second part of the program is called the Comparative Performance Report and will generate two sets of reports, one for the first quarter and another for the second quarter of 1992. We will use some sophisticated statistical calculations to develop lists on ten visit codes. These lists will show, for the physicians who used those codes, how often they were used per patient. The lists will also be made up by specialty. Those physicians who are in the top ten percent of their specialty for using a particular code will get a Comparative Performance Report. Again, these reports are informational, I hope educational, but not punitive or disciplinary. We will *not* calculate an overpayment such as was described in my PAL article in the December 1991 *Colorado Medicine*.

We have already gotten a few records back. One physician accompanied one record with a letter describing

how this patient always requires a lot of time (?counseling time?). His record did not justify his visit code. The documentation simply did not *match* the descriptions of the levels of intensity for the history and exam. However, I suspect that if he had used the counseling time (it was probably more than half the total time), his code would have been justified. Please review the first part of this article and the introductory chapter to the new visit codes in CPT 1992.

A second observation from this very small sample is that the documentation often did not justify the level of code, even considering the possibility that counseling was the major element. Your note should include *all the important* points in the history and positive and negative findings on the exam. This, of course, is not a new requirement, but one that follows from the function of the note; to display as completely and as accurately as possible the patient's clinical state at that time.

If you get a phone call for the records or a Comparative Performance Report and have questions, please call me at 831-5827. Even if you don't get a call or a report, call me if you have any questions. We are going through the greatest change in physician payment since Medicare began paying physicians about 26 years ago. Change, even when it might be for the better, still may be frustrating. But take comfort in the words of an eastern philosopher who said, "To live is to change, and to live well is to change often."



## Medicaid Hint: Don't Duplicate

Medicaid Communications:  
**Practitioner Operations:**  
(303) 831-0504 or 1-800-443-5747.  
**Institutional Operations**  
(303) 831-0214 or 1-800-443-6731.

*"Duplicate claim submissions are the largest single cause of Medicaid claim denials."*

In 1992, the Colorado Medicaid Program will receive and process more than 6 million claims. Approximately 160,000 of those claims will be denied as duplicate submissions — requests for payment of claims that have already been paid. Duplicate claim submissions are the largest single cause of Medicaid claim denials. Duplicate claim submissions increase provider expense directly in terms of billing personnel costs, supplies and equipment, and in related activities such as increased time for reconciliation, auditing and remittance statement posting, shifted resources and reduced productivity. In addition, the administrative costs for processing and denying duplicate claim submission are paid from tax dollars. Everyone loses when duplicate claim forms are submitted.

Medicaid Bulletin B9101105, distributed in December, 1991, provides billing tips and answers to frequently asked questions about duplicate claims. Medicaid Communications Representatives are available by telephone to answer billing questions. Please help eliminate duplicate claim submissions by reviewing your billing procedures to assure that billing practices are efficient and cost effective.

### LOOKING FOR A UNIQUE OPPORTUNITY?

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NAVAL FLIGHT SURGEON

# Letter From The Editor

by Leslie Moldauer, M.D., Denver  
Editor: Colorado Psychiatric Society Newsletter

*Ed. Note: The following is reprinted from the Colorado Psychiatric Society Newsletter, Vol. XVII, No. 1, March 1992*

*"...the normal rules of fidelity in marriage don't need to apply to me."*

This week, my usually calming ritual of viewing the morning news was constantly assaulted by the breaking story of a democratic presidential candidate who was being accused of having a long-term affair. Why are we so fascinated and concerned about the sex lives of presidential candidates, basketball stars, relatives of senators and supreme court nominees. Does one's sex life have any relationship to how one does his job? Does it say something about the person that may be generalized to their judgment or the way that they might handle other types of situations? What do all of these people have in common? They are all men, and they are all nationally recognized. If Bill Clinton wasn't a presidential candidate, then most people wouldn't care who he was sleeping with.

Our culture creates and perpetuates just the kind of behavior that it is so critical of. We choose a handful of people (usually men) who generally have only one hypertrophied talent or skill, and make them our idols. They become the object of respect, jealousy and awe. It is no wonder that there are thousands of women wanting to climb on the bandwagon of the adoration of these "princes" that are larger than life. It is no surprise to me (and I don't understand why it should be to anyone else), that these "supermen" develop a sense of narcissism that defies reality. "I am so handsome, brilliant, talented, etc. . . that the normal rules of fidelity in marriage don't need to apply to me. My wife should be so grateful to be married to me that she should tolerate

my indiscretions whether they be women, gambling, spending money or drugs." And in general the wives are tolerant, either out of loyalty, love or fear.

I have treated several wives of sports superstars. I have found them to be poised, eloquent, beautiful and intelligent. Unfortunately, they are also self-deprecatory, insecure, confused and extremely fearful about their futures. They present similarly to someone who has been traumatized or abused. Their sense of self became uncertain and largely determined by the way that they were treated by their husband. They could not understand how, if they were truly valuable, they could be so devalued by their spouses. Their worth became determined by this over-valued person's view of them. If the whole world respects their husband's opinion of which tennis shoes or which cola to buy, then their unstated opinion of their wife is equally accurate. As a therapist, all the reality testing and insight that I could offer had little impact on my patients' self-esteem. How could my negative view of their husband's actions be accurate, when the whole world idolized them.

Why do we as a society continue to perpetuate this system? Why do we pay men millions of dollars a year because they have a good throwing arm, a quick wit or a handsome face? What are we saying about the role of women in our culture when we do this? Are we not perpetuating an abusive relationship? Finally, how can we be surprised when men act the way that we'd expect them to act when they are aggrandized by an entire nation?





# Insurance Company

**Report to the Membership  
of the  
Colorado Medical Society  
Interim Meeting  
House of Delegates  
March 7, 1992**

by George O. Thomasson, M.D.,  
Vice President for Risk Management  
Copic Insurance Company

Following is the report of Copic Insurance Company given the Colorado Medical Society 1992 Interim Meeting of the House of Delegates by George O. Thomasson, M.D., Vice President for Risk Management.

March 7, 1992

Mr. President, officers, delegates and members: I'd like to remind you of something that I know many of you forget. Copic is your company, and I would like for you to share in the enthusiasm with which we make this report and which I as one of your officers think you should receive a lot of credit for having helped us accomplish.

This, in fact, is Copic's second decade. I want to show you some statistics we think you're most interested in. Since I am your risk manager, I obviously can't resist the opportunity to do a little risk management while you're here.

Looking at our numbers of insured from 1988 in which there were 3,771, 1989, 3,717, 1990 3,653, 1991 3694, and to 1992 with 3,736, I can say that we generally insure about 3,700 physicians in the State of Colorado. For those of you who have heard Bob (Dr. Robert Brittain) and I talk to you in your specialty seminars, you know that represents about 75% of the practicing physicians in Colorado, and we're very happy to see that we continue to represent your interest in that respect.

The following table gives you some idea of the frequency and severity of claims against physicians in Colorado

membership of the Physician Insurers Association of America, in which Copic is a member. Just this last year St. Paul has also demonstrated this frequency decrease and then a small frequency increase.

As you can see, claims severity has continued to increase. This probably reflects better case selection by plaintiff attorneys and a trend toward larger awards in personal injury cases.

The most significant factor though in our experience is for claims (on which we've kept statistical data for more than ten years) when we analyze those that had significant records problems. I'm not speaking about failure to cross a "t" or dot an "i" or to put commas in the wrong place; I'm talking about significant issues that presented a problem to the attorneys who were defending the physicians. Those claims are **twice as expensive** even when we win.

Copic has relocated in its own "home office" building. This means permanent quarters for both Copic and CMS. Land, building and furniture were purchased for less than 50% of replacement cost. As an investment of funds, the building will produce a return better than anything else currently available in financial markets. Being co-located with CMS is a significant advantage in streamlining our communication and planning activities.

Copic Insurance Company Growth and Stability

YEAR	ASSETS	SURPLUS	FREQUENCY (per 100 doctors)	SEVERITY (per closed claim)
1988	\$103,201,000	\$11,026,000	14.93	\$44,444
1989	\$133,643,000	\$14,462,000	14.66	\$57,534
1990	\$135,618,000	\$21,146,000	15.44	\$73,684
1991	\$172,441,000	\$35,629,000	15.27	\$84,614

There was, for a short time, a decrease in frequency of claims, nationally and in Colorado. In the past, St. Paul generally had the largest national representation of physicians. Recently, it was surpassed by the total

The long term financial benefit of this move is obvious.

Copic has also maintained a solid financial position and we have continued the trend of returning dividends



o insured physicians. In 1990, Copic returned \$2.5 million; in 1991, \$3.7 million. This year, that dividend will amount to over \$6 million.

When we saw that medical records claims were twice as expensive as all claims, we developed a records consultation project to assist you in your practice to fine-tune your records. Our experience is that most Colorado physicians are doing an excellent job now with the general issues that we've always talked to you about. They are legibility, organization of the record and informed consent. And for you to reach that next level of sophistication, we need to be working with you in your practice because that's *where the rubber meets the road*, as they say.

Doctor-patient conflicts are always a significant issue, as you heard Corky (Dr. Butler) mention earlier. Physicians are more and more in conflict with one-another, with the public, with society, with regulatory agencies, and so on, and we need to improve our communications skills. Therefore, we have been conducting the Miles Communications Workshops for the past year. You have received some national recognition for your willingness as Colorado physicians to participate in these workshops, and you will continue to do so.

The most expensive group of claims nationally is also the most expensive in Colorado's experience. It is 'failure to diagnose cancer' claims - claims in which the physician allegedly has failed to make a timely diagnosis of cancer. We have a project funded by the Agency for Health Care Policy and Research (AHCPR) in which we're participating with Rose Hospital and AMC and which is just starting. Many of you will have an opportunity to participate in that. We hope it will give us some extra tools in supporting you, should that allegation be made against your practice.

And, of course, the most important part is knowing how to pull together all of those issues we've presented to you (Bob Brittain, Kathy Gardner and me) in our seminars. We know that you have a limited amount of time in your practice. There are a lot of things that distract physicians these days from their ability to concentrate on their patients, the reasons we're in this business. In Risk Management, we're trying to intensify our time working with you in the office and particularly in relation to specialty-specific issues. We have reviewed 1,016 physicians in our Records Consultation Project. 67% of those reviews have resulted in what we refer to as "compliance," or complying with the criteria. In 30%, moderate problems were noted. Problem statements, treatment plans, and legibility were present in 95%. In those patient record reviews, we found that

80% had an allergy flag present, 60% contained a medications list, 50% also had an up-to-date problem list. One of the most rapidly growing areas of claims these days is the area in which there are drug-related problems with the patient. Incomplete information increases that risk. These are the things we have presented to you most pointedly in the last five or six years. You're obviously doing a great job because out of the more than one-thousand, serious problems were noted in only 3%.

Other things we thought you'd be interested in knowing about - your ability to review x-ray and laboratory data - which was what led us to talk to you about system failures. You obviously got the message, because in 99% of the reviews, a lab/x-ray data review system was in place; 60% of the reviews revealed that the lab/x-ray review was well documented. It is actually unusual for us to now find a laboratory/x-ray or consultant report that slips through without a system being in place. Unfortunately, the systems aren't quite as precise as we would like for them to be, but we think that just represents some inexperience in using the systems. They're obviously there.

The most consistent findings (and you should think about this a little) is, first, that the more specialized the practice the less general health information is obtained. One of the things we've talked about to many of you who are specialists is that you still tend to participate in coverage activities or in sharing patient care with partners or other people who represent the general level of your profession, such as endocrinologists who still cover for general internists. If you fail to collect some of that other information you may, in fact, face a claim situation outside your specialty. This is a very important issue to keep in mind. It's also important as an orthopedist, for instance, to know if your patient is a diabetic or is taking significant long-term medication. Second, dictated office notes are always more complete, no matter what the specialty is, and we will continue to encourage you to move to dictated and transcribed records for that particular reason.

Communication is going to be our watch-word for the next few years. You know that the MCAT now requires a communication component and successful completion by the applicant. Our first approach is the Miles Communications Workshops. Twenty-four of these workshops have been conducted throughout the state. Three-hundred, seventy-five of you have participated, along with fourteen non-physician providers. Our feedback has been uniformly positive. The attention that you've received has given us an opportunity to participate in a two-state grant proposal with Oregon. The

grant will probably be funded by AHCPR to, for the first time, effectively look at the participating physician and obtain feedback about useful communication skills. The study, being constructed by Dr. Wendy Levinson of Portland, will help determine the degree of actual learning and behavior change among participants in the workshops. Both Oregon and Colorado physicians are expected to be included in the sampling.

The Copic Partners for Prevention program (which we will be conducting with Rose Hospital and AMC under the AHCPR grant) is just getting started. This is an attempt to evaluate educational and screening activities. It's not diagnostic and treatment-oriented. One of the things we still believe to be the most effective risk management strategy you can develop is the trust relationship between yourself and your patients. In cancer screening, part of that is helping them understand the importance of their own responsibility for cancer evaluation and particularly the importance of adhering to your follow-up instructions. So the key in this study will be to learn how to do that more effectively and to motivate patients to follow our advice in a significant fashion.

One of our major seminar subjects is the Specialty-specific Risk Management Self-Assessment for all physicians.

For RECORDS, be sure they're legible, that there is a clear problem statement for each case, and there is a well-defined plan of management and program of education. Then double check to see that your signature is properly affixed. Included in SYSTEMS, make sure there is a review system for lab and x-ray reports and these are well documented. Be sure there is a system to follow when **appointments** are missed, and be sure to schedule and follow through with regular **staff meetings**. Under the file heading of PROBLEM PATIENTS, maintain an index of **suspensions**, any **unusual diagnosis**, **cultural concerns**, concerns about **behavior**, and then document any **transfer decisions** made. COMMUNICATIONS should include proper recording of the **patient's expectations** as well as the **physician's expectations**, any **billing**, **insurance** or **language questions** or comments.

The specialty-specific seminars we are involved in incorporate some common data bits for all specialties, and, of course, the issue of communications.

We've divided the specific medical risk by specialty. In Family Practice, medical problems include Cancer (breast, lung, colon, skin and cervix), Myocardial Infarction, Pregnancy-related (prenatal system), Infec-

tions (meningitis, epiglottitis), and Drug Related (combinations, allergies, anticoagulants, long-term steroids, refills without visits and contraindications).

In Internal Medicine: Cancer, Myocardial Infarction, Procedure Consent Form (endoscopy, organ biopsy), System Failure (chest x-ray after subclavian, annual PAP and breast exams), and Drug Related (combinations, allergies, anticoagulants, long-term steroids, refills without visits, contraindications, chemotherapy and antibiotic side-effects).

Surgery-specific surgical problems include **Judgment Errors** (intrathoracic mass-meningocele, tracheostomy - slipped, retroperitoneal tumor-vascular injury, vascular repair), **Informed Consent Errors** (carotid endarterectomy, sigmoidoscopy, C-section, thyroidectomy, hernia repair, vasectomy), **Questionable Indications** (hiatus hernia, acalculus cholecystectomy, obesity procedures, new procedures), **System Failure** (wrong side/site, retained sponges, preoperative data review errors), and **Technical Errors** (bovie burns, laparoscopic procedures, laser procedures).

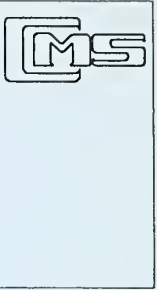
So these are examples of the issues in specialty-specific areas which have most frequently resulted in suits against the FP, internist or surgeon. We have these for several other specialties, but I use the above to illustrate what Copic is attempting to do in risk management.

Copic understands that our projects are just another hassle-factor in your practice, and we truly appreciate your participation and willingness to incorporate these subjects into your practices. All this is, I believe, reflected in the financial information I presented at the outset.

Thank you.







*Harrison G. Butler, III, MD, President of the Colorado Medical Society listens to Patricia A. Nolan, MD, MPH, explain her vision for Public Health in Colorado. Dr. Nolan has been appointed by Governor Roy Romer to head the Colorado Department of Health.*



*James S. Todd, MD, Executive Vice President of the American Medical Association makes a point as he addresses the General Membership meeting of the Colorado Medical Society, held March 7, 1992. Dr. Todd asked for the support of the CMS in national issues faced by the AMA, noting that progress is being made on many concerns vital to the practice of medicine. He was introduced by President H. G. Butler, III, MD who said that the two physicians had arrived at an understanding on some of the issues on which Dr. Butler differs with the AMA.*



*Auxilian Bunkie Inkret stopped by to inspect the prizes in a drawing operated by Mary Hanson and Rose Pollard to raise funds for AMA-ERF*

# Proceedings of the Interim Meeting Colorado Medical Society House of Delegates

March 8, 1992

Sheraton Hotel — Englewood, Colorado

## PROCEEDINGS OF THE HOUSE OF DELEGATES

The Colorado Medical Society House of Delegates met at the Sheraton Denver Tech Center, Englewood, Colorado on March 7 & 8, 1992 and took the following actions.:

### REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BYLAWS

**Adopted** a Resolution which requires the Nominating Committee to distribute copies of the President-Elect's resume to the Delegates prior to election.

**Adopted** a Resolution to form a Task Force to review the Medical Practice Act for the purpose of recommending changes prior to the Sunsetting process in 1994.

**Adopted** a Resolution encouraging the Colorado Medical Society Leadership and members in general to join COMPAC/AMPAC.

**Adopted** a Resolution calling for the American Medical Association to educate the public regarding the meaning of recognized board certification.

**Adopted** a Resolution inquiring into the possibility of publishing a proactive newsletter for patients.

**Adopted** a Resolution to form a Task Force which will further define CMS policy on health care reform.

**Adopted** a Resolution which calls for the American Medical Association to reaffirm its goals to be an unified voice for all physicians.

**Adopted** a Resolution to adopt as CMS policy the guidelines **Adopted** by the American Medical Association on the ethical obligation to report impaired, incompetent or unethical colleagues.

**Adopted** a Resolution to adopt as CMS policy the guidelines **Adopted** by the American Medical Association on conflict of interest.

**Accepted** for filing:

- Progress Report - Board of Directors,
- Progress Report - Executive Director
- Progress Report - AMA Delegation
- Progress Report - Women in Medicine Section
- Progress Report - Young Physician Section



## REFERENCE COMMITTEE ON PROFESSIONAL EDUCATION/LEGISLATION

The following Resolutions were **referred**:

RES-6-A Training Programs for Physicians to Improve Counseling Skills with HIV Positive Patients

RES-7-A Training Programs for Physicians to Improve Counseling Skills with Adult Survivors of Sexual Abuse

RES-11-P Legislation Prohibiting Nonsale Distribution of Tobacco Products

RES-12-P Legislation to Prohibit Sale of Tobacco Products in Vending Machines

**Accepted** for filing:

Progress Report - Council on Legislation

Progress Report - Council on Legislation, COMPAC

Progress Report - Council on Professional Education

## REFERENCE COMMITTEE ON COMMUNITY HEALTH ISSUES/MEDICAL SERVICE

**Adopted** a Resolution calling for government officials and legislators to enact ordinances and legislation to prohibit smoking in all municipal buildings, open stadiums and other facilities throughout the state.

**Adopted** a Resolution asking for the Task Force on Domestic Violence to develop a model protocol to assist physicians in recognizing, reporting, treating and referring victims of domestic abuse.

**Adopted** a Resolution which calls for the Colorado Medical Society to develop a model job description for Medical Directors of nursing homes which would include educational requirements, experience or certification in geriatrics.

**Adopted** a Resolution which calls for the Colorado Medical Society to support accurate and appropriate labeling of so called "non-alcoholic" beverages and other substances including over-the-counter and prescription medications.

**Adopted** a Resolution which states that the Colorado Medical Society support the development of a more rational definition of contaminated waste and rational policy for disposal of contaminated waste associated with delivery of medical care.

**Adopted** a Resolution which states that the Colorado Medical Society encourage the American Medical Association to analyze the National Practitioner Data Bank statistical report and share that report at the 1992 Annual Meeting.

**Adopted** a Resolution which asks that the American Medical Association encourage the development of educational materials which enhance the awareness of the safe and unsafe use of non-powder guns.

**Adopted** a Resolution which asks that any transportation and disposal of radioactive waste be thoroughly coordinated among federal, state and local governments as well as potentially involved medical facilities.

**Adopted** a Resolution that the Colorado Medical Society encourages the American Medical Association continue its evaluation of state or other approaches to developing a Basic Benefits package and continue coordination of activities regarding Health Access America.

**Adopted** a Resolution that the Colorado Medical Society oppose product-specific advertising of prescription drugs directly to the public.

**Adopted** a Resolution that the Colorado Medical Society urges the AMA to encourage its members to gather signatures from patients to be presented to congressional delegations demanding that the United States Government discontinue spending tax dollars in support of the tobacco industry.

**Adopted** a Resolution that the Colorado Medical Society urge the AMA to study the issue of limits on health insurance benefits for **Adopted** children and to identify appropriate remedies with a report to the AMA House of Delegates.

**Adopted** a Resolution that the Colorado Medical Society support the AMA position that the appropriate use of animals is essential to the progress of medical research.

**Accepted** for filing:

Progress Report - Council on Medical Service  
Progress Report - Council on Community Health Issues  
Report of the AMA Board of Trustees, Health Access America

The following resolutions were **referred**:

RES-13-P HIV Testing in Patients  
RES-14-P Changes to Community Health Issues Section of the Policy Manual  
RES-18-P HIV Testing without Explicit Consent  
RES-36-P HIV Infection in Health Care Workers

The following resolutions were **Not Adopted** :

RES-4-P Credentialling of D.O.'s  
RES-5-P HIV Testing  
RES-29-A Misleading Reference to Animal Research by Encyclopædia Britannica

#### REFERENCE COMMITTEE ON PHYSICIAN/PATIENT ADVOCACY COUNCIL

**Adopted** a Resolution that the Colorado Medical Society educate its members regarding actions taken by congress regarding medicare reimbursement for EKG interpretation and encourage the Colorado Delegation by letters and personal contact to support Senate Bill 1810 and House Bill 3373 which will repeal such actions.

**Adopted** a Resolution which provides for an ongoing study of the impact of managed care on physicians and patients of Colorado and to report at the Annual Meeting 1992.

**Adopted** a Resolution which states that the Colorado Medical Society shall adopt as policy that all third party payors be required to disclose in clear terms to policy holders any restrictions which may affect access to the patient's choice of physician.

**Adopted** a Resolution asking that immediate steps be taken to influence the Secretary of Health and Human Services to allow an exception to the Stark anti-self-referral law for any private office laboratories that do not "abuse the Medicare program".

**Adopted** a Resolution that the Colorado Medical Society urges the American Medical Association to work immediately with specialty societies to clarify the meaning and scope of global fees so that patients will be provided appropriate care and that appropriate payment will be made for essential professional services.

**Adopted** a Resolution directing the Executive Director and legal counsel to prepare a response to the Center on Deafness' interpretation of the Americans with Disabilities Act regarding payment for services of an interpreter during medical treatment.

**Accepted** for filing:

AMA-4 - Final Rule of the New Medicare Physician Payment System  
Progress Report - Council on Physician/Patient Advocacy

The following report was **referred**:

AMA-2 Managed care" Report of AMA Councils on Medical Service/Long Range Planning

The following resolution was **Not Adopted** :

RES-30-A Ongoing Study of Managed Care



# Delegate Attendance — 1992 Interim Meeting

## **DISTRICT I - 5 DELEGATES**

**EASTERN COLORADO - 1 DELEGATE**

(A) Olson, Mark R.

**MORGAN - 1 DELEGATE**

(D) Thompson, Patrick L.

**NORTHEAST COLORADO - 2 DELEGATES**

None Present

**WASHINGTON-YUMA - 1 DELEGATE**

None Present

## **DISTRICT II - 6 DELEGATES**

**INTERMOUNTAIN - 2 DELEGATES**

None Present

**LAKE - 1 DELEGATE**

None Present

**MOUNT EVANS - 1 DELEGATE**

None Present

**MOUNT SOPRIS - 3 DELEGATES**

(D) Painter, M. Ray

## **DISTRICT III - 12 DELEGATES**

**NORTHWESTERN COLORADO - 2 DELEGATES**

None Present

**CHAFFEE - 1 DELEGATE**

None Present

**FREMONT - 2 DELEGATES**

(D) Buglewicz, John V.

(D) Gamache, Peter J.

**HUERFANO - 1 DELEGATE**

None Present

**LAS ANIMAS - 1 DELEGATE**

(D) McFarland, Douglas M.

**OTERO - 2 DELEGATES**

None Present

**SAN LUIS VALLEY - 2 DELEGATES**

(D) Culp, Raymond M.

**SOUTHEASTERN COLORADO - 1 DELEGATE**

None Present

## **DISTRICT IV - 6 DELEGATES**

**CURECANTI - 2 DELEGATES**

(A\*) Canfield, Thomas M.

**DELTA - 1 DELEGATE**

(D) Bennett, Robert J.

**LA PLATA - 2 DELEGATES**

(A) Glann, Alan S.

**MONTEZUMA - 1 DELEGATE**

None Present

## **DISTRICT V - 22 DELEGATES**

**ARAPAHOE - 22 DELEGATES**

(D) Barte, Roy M.

(D) Bartlett, Max D.

(A) Fox, Lisa A.

(D) Jolly, Susan L.

(D) Kruse, Robert L.

(D) Larkin, Thomas P.

(D) Levine, Mark A.

(A\*) Lewis, Frederick

(D) Reiner, Seth A.

(D) Stecher, Karl

(D) Thulin, Barbara W.

(D) Truitt, Leigh

## **DISTRICT VI - 11 DELEGATES**

**AURORA-ADAMS - 11 DELEGATES**

(D) Capin, Leslie R.

(D) Clark, Sallie B.

(A) DiBella, Nicholas J.

(A) Gottula, Roderic D.

(A) Iskander, Laurice

(A) Jacobs, Mary Jo

(D) Kraus, G. Thomas

(A) Soloman, William A.

(D) Sundland, Barry R.

(D) Visconti, Paul B.

(D) Vitanza, Joanne M.

## **DISTRICT VII - 12 DELEGATES**

**BOULDER - 12 DELEGATES**

(A\*) Bedell, Richard F.

(D) Benson, Alan E.

(D) Berg, Kevin R.

(D) Bolles, Gene E.

(A) Curtis, William S.

(D) Farrington, John F.

(D) Rubright, Mark W.

(D) Rupp, Gerald R.

(D) Stjernholm, Melvin R.

## **DISTRICT VIII - 20 DELEGATES**

**CLEAR CREEK VALLEY - 20 DELEGATES**

(A) Augustitus, V. Karen

(D) Brundige, Richard L.

(D) Campbell, Thomas P.

(A) Chambers, Jodi A.

(D) Cohen, Richard S.

(D) Doig, David J.

(D) Dorr, Eugene A.

(D) Doyle, Herman E.

(D) Karlin, Joel M.

(D) Laubach, Sherri J.

(D) Netz, Howard E.

(D) Oppenheim, Walter H.

(D) Potts, William E.

(A) Rail, Carla J.

(D) Sadler, Dean L.

(A\*) Tegtmeier, Ronald E.

(D) Yakely, M. Robert

(A\*) Yocum, Harold A.

## **DISTRICT IX - 42 DELEGATES**

**DENVER - 42 DELEGATES**

(D) Anneberg, A. Lee

(D) Bailey, William C.

(D) Bakemeier, Richard F.

(A) Ballinger, Carter M.

(A) Bogin, Robert M.

(D) Butterfield, Donald G.

(D) Butterfield, L. Joseph

(D) Campbell, William A.  
 (D) Carson, Bonita S.  
 (D) Cochrane, David R.  
 (D) Cook, William R.  
 (D) Fink, Donald W.  
 (D) Foust, Glenn T.  
 (D) Gottesfeld, Ray L.  
 (D) Halgrimson, Charles G.  
 (A) Jacobson, Eugene D.  
 (A) Kandel, George E.  
 (D) Karel, James L.  
 (D) Major, Francis J.  
 (D) McCartney, Robert D.  
 (A) McDonald, Louise L.  
 (D) McElhinney, James P.  
 (A) Moore, George E.  
 (D) Nelson, Nancy E.  
 (A) O'Donnell, Richard S.  
 (A) Owens, J. Cuthbert  
 (D) Parsons, Donald W.  
 (D) Regan, James R.  
 (D) Safford, H.R.  
 (D) Sawyer, Robert B.  
 (D) Schemmel, Janet E.  
 (D) Sides, Leroy J.  
 (A) Stigler, Del  
 (D) Walker, Louise C.  
 (D) Wiedel, Jerome D.  
 (D) Zbylski, Joseph R.  
 UNIVERSITY OF COLORADO STUDENT MEDICAL  
 SOCIETY - 2 DELEGATES  
 (D) Batuello, Stephen G.  
**DISTRICT X - 19 DELEGATES**  
 EL PASO - 19 DELEGATES  
 (D) Barry, Francis J.  
 (A) Bengfort, John L.  
 (D) Brusenhan, J. Richard  
 (D) Crawford, Lewis A.  
 (D) Emeis, William E.  
 (A) Geiringer, Gary V.  
 (D) Gifford, Marilyn J.  
 (D) LaVoo, John W.  
 (D) Lewis, Ted T.  
 (A) Lloyd, William E.  
 (A) Murray, Carolyn J.  
 (D) Muth, John B.  
 (D) Nielson, Peter G.  
 (A) Pollard, Joseph S.  
 (A) Rapp, Alan D.  
 (D) Rubinow, Sidney D.  
 (D) Spaulding, Duane R.  
**DISTRICT XI - 10 DELEGATES**  
 LARIMER - 10 DELEGATES  
 (A) Chase, Jerry A.  
 (A) Ezell, William W.  
 (D) Giansiracusa, Richard F.  
 (A) Hailey, Mark A.  
 (D) Hammond, Richard O.  
 (D) Honea, Bertrand N.

(D) Hughes, Andres G.  
 (D) Kaiser, Dale C.  
 (A) Tagge, Gordon K.  
 (D) Wera, Thomas J.  
**DISTRICT XII - 6 DELEGATES**  
 MESA - 6 DELEGATES  
 (D) Doran, John H.  
 (D) Hanna, Robert S.  
 (D) Jones, Paul B.  
 (D) Magraw, Bronwen J.  
 (D) Golter, Lee B.  
 (D) Sadler, Theodore R.

**DISTRICT XIII - 9 DELEGATES**  
 PUEBLO - 9 DELEGATES  
 (D) Gaide, Thomas K.  
 (A) Kessler, Sharon M.  
 (D) Meeuwsen, James W.  
 (A\*) Puls, Theodore J.  
 (A\*) Nevin-Woods, Christine R.  
 (D) Ryals, Jarvis D.  
 (D) Tonsing, Robert E.  
 (A) Wilz, William P.  
 (A\*) Woods, Phillip H.

**DISTRICT XIV - 8 DELEGATES**  
 WELD - 8 DELEGATES  
 (D) Olds, Kenneth M.  
 (A) Quinn, Richert E.

MEDICAL STAFF SECTION - 1 DELEGATE  
 None Present

COLORADO ACADEMY OF FAMILY PHYSICIANS - 1  
 DELEGATE

None Present

COLORADO CHAPTER, AMERICAN COLLEGE OF  
 PHYSICIANS - 1 DELEGATE

None Present

COLORADO SOCIETY OF INTERNAL MEDICINE - 1  
 DELEGATE

None Present

ROCKY MOUNTAIN GASTROENTEROLOGIC SOCI-  
 ETY - 1 DELEGATE

None Present

COLORADO ORTHOPÆDIC SOCIETY - 1 DELEGATE

None Present

COLORADO SOCIETY OF ANESTHESIOLOGISTS - 1  
 DELEGATE

None Present

COLORADO CHAPTER, AMERICAN COLLEGE OF  
 SURGEONS - 1 DELEGATE

None Present

COLORADO CHAPTER, AMERICAN COLLEGE OF  
 EMERGENCY PHYSICIANS - 1 DELEGATE

(D) Lefkowitz, Donald J.

COLORADO RESIDENT PHYSICIAN SECTION - 1  
 DELEGATE

None Present

COLORADO GYNECOLOGICAL & OBSTETRICAL  
 SOCIETY - 1 DELEGATE

None Present

COLORADO YOUNG PHYSICIANS SECTION - 1



## Auditor to Keep Eye on DGH

Robert L. Crider, City Auditor, announced the selection of Ruben Esquibel, Jr., CPA, to manage the newly established Office of the Auditor at Denver General Hospital.

This action fulfills a major promise made during Auditor Crider's 1991 Campaign to help with some of the financial problems that have been ongoing at Denver General Hospital. Mr. Esquibel is the first person to serve in the role of Special Assistant to the Auditor for Denver Health and Hospitals.

## Juvenile Health Standards Revised

The National Commission on Correctional Health Care (NCCHC) has just released the revised *Standards for Health Services in Juvenile Detention and Confinement Facilities*. First issued in 1979 and revised in 1984, this is the only comprehensive publication regarding minimum standards of health care services in juvenile detention and confinement facilities.

The sixty-five standards, grouped into administration, health records, personnel, care and treatment and medical/legal issues, address the specific health needs of a juvenile population. There are five new standards, regarding the right to refuse treatment, sexually transmitted and bloodborne diseases, medical clearance upon admission, outside programs such as Outward Bound and forestry camp and the forensic role of health care staff. These standards are used in the accreditation of juvenile detention facilities.

The NCCHC was founded by the American Medical Association to improve the quality of health care in prisons, jails and juvenile detention and confinement facilities. Accreditation programs for the county jails in Colorado are administered by the Colorado Medical Society through its Colorado Jail Health Care Project, coordinated by Ellen Stein, Director of Health Care Policy. For more information, contact the Jail Project at (303) 779-54556 or the NCCHC at (312) 528-0818.

## Disability: The Proactive Approach

The 1990 "Americans with Disabilities Act" (ADA) and the regulations which implement it have given physicians cause to fear excessive governmental interference in the physician/patient relationship. In addition, activist groups for the disabled have recently made noise about requirements which would severely hamper a physician's ability to conduct business. While CMS legal counsel is busy researching the legal implications of these new regulations (especially the ones that concern your disabled patients), there is something you can do.

A coalition of disability groups and businesses are sponsoring a workshop April 30 - May 1 called "Employment in the 90's Investing in Ability." While the ADA is not the prime focus of this conference, it does figure prominently, as it must in any current discussion of disabilities. The conference really takes a much more positive approach than merely explaining how to meet requirements. It is designed to promote greater productivity by actively encouraging employment of the disabled.

"It sounds like a worthy goal," you say, "but how realistic is it? After all, wouldn't I have to make major modifications to my office and practice?" You'll have to go the conference to find out, but it doesn't look that way. You may recall in the early 1960's when a few far seeing zealots started talking about a radical new idea called "conservation." Today, virtually every area of business and life is affected by environmental concerns. This may be your chance to get in on the cutting edge of the new mentality. Hire the disabled because it's good for you, good for them and good for society.

This conference will deal with issues faced by every employer in conforming to the standards of the ADA and in moving constructively into the future. Though not specific to physicians, it will give information on how to hire the disabled and profit from the experience. Look for more specific information on physician compliance with the provisions of the ADA in the May issue of *Colorado Medicine*.

Mail in registration deadline for this conference is April 10. It's \$55 if you pre-register, \$75 at the door, but there are no guarantees there will be space. For registration information (there is a host of highly qualified speakers) call 861-0116 (TTY 861-2734).

The conference will be followed by a Job Fair for the disabled on May 13. Once you become so excited about the possibilities of hiring the disabled (and who better to show this kind of concern than a physician?) you will want to make the contacts necessary to begin the process. Call 233-1666 (TDD 861-2735) to find out how to get involved.



# Colorado Gynecological and Obstetrical Society

by Betsy Fox

## Sexual and Domestic Abuse and AIDS

The President's Symposium on Sexual and Domestic Abuse and AIDS was held Friday, March 13, at the Hyatt Regency Denver Tech Center and was a resounding success. Over 200 participants heard Marilyn Van Derbur Adler give the morning keynote address, Ken Hamblin give the luncheon address and other excellent presentations throughout the day.

Participants included Ob/Gyn physicians, nurse practitioners, certified nurse midwives, other physician specialists, community representatives and office personnel. The Planning Committee consisted of Jaime McGregor, Betsy Fox, Cheryl Welch and Deborah Haack. Pharmaceutical support came from: Wyeth, Ortho, Merck, Berlex, Tokos, Care Mark, Healthdyne and Vital Med.

These two themes are vital to women's health care. Experts in both fields shared information, generating provocative questions and a desire from all to work in prevention and solutions, with a true sense of urgency.

## Legislative Dinner

The annual Legislative Dinner was held on March 11 at the Oxford Hotel. This year, a theme of Women's Future Health Care was presented by immediate past president Harvey Cohen. Alan Rapaport, Chair of the Legislative Committee, served as emcee of the evening.

This special evening was highlighted by the attendance of many

legislators, as well as community representatives from the Baby Your Baby program, State Health Department, Social Services, State Nursing Program and State Family Planning Program. Sixty five people attended. This dinner was sponsored by Wyeth and Tokos.

## Teen Pregnancy Program

The Teen Pregnancy Initiative sponsored by the Society has received an ad campaign portfolio from the Denver Ad Federation. This statewide advertising council has been developing a theme, logo and strategic plan for an advertising campaign which will occur in 1992, with the focus of lowering teen pregnancy.

## Legislative Breakfast

The Legislative Breakfast was held on Valentine's Day, February 14, at the State Capitol. Many legislators, Ob/Gyn physicians and staff members enjoyed good conversation and refreshments featuring a Valentine's Day theme. This event was sponsored by Wyeth and Tokos.

## Marriott Meeting

The monthly membership meeting will be held April 6 at the Marriott, I-25 and Hampden, cocktails at 5:45, dinner at 6:45. The evening will feature Richard Schwartz, MD, President of the American College of Obstetricians and Gynecologists and Professor and Chair at SUNY Downstate Medical Center. The topic will be: Advancing Women's Health.

*For more information, call Betsy Fox at 355-8845.*



*Publication of any advertisement in Colorado Medicine is not an endorsement by the Colorado Medical Society of the product or service. Colorado Medicine magazine is the official journal of the Colorado Medical Society, and is authorized to carry General Advertising.*

## ◆ PROFESSIONAL OPPORTUNITIES

### PRIMARY CARE PHYSICIAN—

Greater Denver. Weekdays Mon-Fri. Prefer full time or regularly scheduled part time. Preventive care, diagnosis/treatment of acute and chronic illnesses of MR/DD clients. Salary guaranteed plus paid malpractice. Contact Steven Parker, MD, Columbus Medical Services, 2000 Valley Forge Towers, King of Prussia, PA 19406. Call toll free 1-800-733-5116. 1/0492

**INTERNIST WANTED:** Rapidly expanding, multispecialty group seeks additional Internist for an established practice. Guaranteed salary, incentive bonus plus benefits. Shareholder status within one year. Send CV to: Debbie Welle-Powell, Focus Health Services, PC, 200 West County Line Rd #130, Highlands Ranch, CO 80126. 2/0492

**ORTHOPEDIC SURGEON—**Colorado Springs—Large, multi-specialty prepaid and fee for service group seeking BC/BE Orthopedist. Guaranteed first year salary with benefits, plus incentive arrangements. Please send CV to: William R. Truitt, MD, Colorado Springs Medical Center, PC, 209 South Nevada Ave, Colorado Springs, CO 80903 3/0492

**FAMILY PRACTICE—**Colorado Springs—Thirty five physician multi-specialty group is seeking BC/BE Family Practitioner for branch office in Colorado Springs. Fee for service and pre-paid practice. Guaranteed salary. Please send CV to: William R. Truitt, MD, Colorado Springs Medical Center, PC, 209 South Nevada Ave, Colorado Springs, CO 80903. 3/0492

**FAMILY PHYSICIAN;** Community Health Center seeks BC/BE Family Physician for group practice north of Denver. Loan Repayment opportunities. Duties include full Family Practice (including OB) with staff of seven physician. Comprehensive benefits, pail malpractice, CME, competitive salary, very attractive location. Please send CV or inquiries to David Myers, 1115 2nd Street; Fort Lupton CO 80621, or call (800) 388-HEAL. 6/0292

**EMERGENCY MEDICINE—**Community Hospital. Hours: four 12-hour shifts—6pm-6am Weeknights. 60 hour shift 6pm Fri-6am Mon. ER Dr. sees average 5-8 pts/12 hr & 40-45/60 hr. Compensation: Negotiable, pending insurance. lots of time for 3 R's: Rest, Relax & Read/TV. Contact: Donald P. Ferrell, MD (719) 846-9213, PO Box 930, Trinidad, CO 81082. 4/0292

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Excellent opportunity for Board Certified or Eligible OB/GYN PHYSICIAN to join twenty five physician, well established multi-specialty group. Position available immediately with full practice due to recent relocation of one of two associates in the OB/GYN Department. Will join a well established Board Certified OB/GYN physician. Good starting salary with an incentive program. Excellent corporate fringe benefit program. Practice situated in medium size city 45 miles north of Denver, Colorado, in the beautiful front range of the Rockies. Contact: Administration, Longmont Clinic, PC, 1925 Mountain View Avenue, Longmont, CO 80501. (303) 776-1234 (collect). 3/0292

**VAIL/BEAVER CREEK—**Family Practice based multi-specialty group seeking two BC/BE Family Physicians for expansion to third office. Full range of FP, including OB & sports medicine in beautiful mountain community. Send CV to Vail Mountain. Medical, 181 W. Meadow Dr. #200, Vail, CO 81657, Attn: K. Petrie, MD 3/0392

**COLORADO SPRINGS GENERAL SURGERY** Hospital based practice available. Sale includes Penrose Hospital office lease, equipment, patient records, managed care contracts and referral base. Reply to 25 E Jackson Ste #305, Colorado Springs CO 80907, (719) 636-0075 c/o Marge Kilgore. 6/1291

**BOULDER— AMBULATORY CARE CLINIC—**Family Medicine/Emergent Care/ Occupational Medicine - Busy, two physician practice seeking full time BE/BC Family Practitioner to join growing comprehensive medical practice in prime SE Boulder area. New, well equipped facility. Minimal call. Flexible scheduling. Send CV and call Dr Offner, 4800 Baseline, D-106, Boulder, CO 80303. (303) 499-4800. 2/0292

**BC/BE INTERNIST—**needed to join busy 2 man Internal Medicine practice—Southwest suburban Denver area — on site treadmill/ Flex sig. Send CV to G. Brown, MD, 6169 S Balsam Way #240, Littleton CO 80123. 3/0292

## Correction

In the article about the Respiteer<sup>TM</sup> Respite Care Program in the December 1991 issue of Colorado Medicine, it was erroneously reported that the MEDICAL PERSONNEL POOL® offices in Denver, Colorado Springs and Pueblo are operated by MEDICAL PERSONNEL POOL, INC.

The Denver MEDICAL PERSONNEL POOL office is, in fact, operated by MEDICAL PERSONNEL POOL, Inc.; however, the Colorado Springs and Pueblo MEDICAL PERSONNEL POOL offices are operated by Medical Personnel Pool of Southeastern Colorado, Inc.



# Classified Advertising

**FAMILY PRACTICE** associate, Boulder, Colorado. Busy Two person practice seeks third BC/BE full or part time associate. No OB. Call L. Wood, MD at (303) 444-8835 for information. 6/0292

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**FAMILY PRACTICE—HOSPITAL SPONSORED CLINIC OPPORTUNITY.** Dynamic, growth oriented hospital in beautiful North Central Wisconsin is seeking Family Physicians to respond to growing community demand. The administrative burdens of medical practice will be minimized in this hospital managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact **Kari Wangsness, Associate, The Chancellor Group, Inc., France Place, Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota, 55435, (612) 835-5123.** tfn/1190

## ◆ SITUATIONS WANTED

**OTOLARYNGOLOGIST**—available as LOCUM for your practice. BC, Well-trained, semi-retired. Available on short notice. Call Nicholas Schenck, MD, FACS, (213) 654-6400. 6/0192

## ◆ PROPERTIES FOR SALE OR LEASE

### MONTANA RANCH

8,000 acres of spectacular meadows, pine and aspen forests. Exceptionally furnished 5 BR, 3 BA log house. Excellent for several families. Located near Big Horn River and Custer Battlefield. Easy interstate drive. 7 hours from Fort Collins. Horseback riding, swimming and mountain bikes available. Stocked trout pond. \$1,750/week. Call (303) 223-8915. 3/0492

**WINTER PARK—HIGHLANDS**—3 BR House, 7 miles from ski area. 1,600 sq ft, Kitchen, Dining Room, Large Living Room. 1,200 sq ft walkout basement, 2 balconies, 2 car heated garage, 1 3/4 acre of property for sale by owner. Asking price is less than we paid. Call owner, Werner or Ruth, 399-8919 12/0491

**MEDICAL SPACE FOR LEASE**—Excellent location near I-25 and Hampden. 10 minutes to Swedish and Porter Hospitals, 15 minutes to Aurora Hospitals. 1575 sq ft finished space. Four examining rooms, two private offices, lab, 2 baths, receptionist area and waiting room. Available March 1. 770-0436 or 795-0469. 2/0392

**YOU OWE IT TO YOURSELF!** Winter Park, very plush 2 BR Condo with all amenities including sauna, athletic club, door to ski area transportation. For sale by owner. Call Werner or Ruth, 399-8919. 12/0491

**EAGLE/VAIL** fully equipped luxury townhouse on golf course, 4 bedrooms, 3 baths, reasonable summer-winter rates. Peter Gehret, MD (303) 771-0456. 12/0492

## ◆ PRACTICES FOR SALE

Large **FAMILY PRACTICE** and **INDUSTRIAL MEDICINE** practice for sale in Aurora, CO. Marvin N. Cameron, MD, 651 Potomac St, Suite B, Aurora CO 80011. Phone 364-4553. 2/0492

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## ◆ SERVICES

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### LOCUM TENENS SERVICE RADIOLOGISTS AVAILABLE

Since 1979, Western Physicians Registry has been providing radiologists throughout the Western States. For locum tenens or permanent positions, please call Jim Ellis, Director. 1-800-437-7676. 6/0292

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Let us help lower your costs. **YOU** specialize in patient care. **WE** specialize in insurance billing. We work with Medicare, Medicaid, HMO's, PPO's, and other third party carriers. **We don't get paid until you get paid.** For more information call Advanced Professional Services (303) 341-1008.

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**INNOVATIONS SHOULD BE PATENTED** if marketable. For more information, call Brian D. Smith of Fields, Lewis, Pittenger & Rost, Colorado's leading patent law firm. Mr. Smith specializes in the medical arts. (303) 758-8400. 12/0791

## ◆ MISCELLANEOUS

We are looking for qualified buyers, sellers, associates, and merger candidates. We also have excellent practice opportunities throughout the state. For more information, call AF-TCO (303) 795-8800. 24/4189





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# Maintaining the Balance



## Americans with Disabilities Act: (ADA) Its Impact On Your Practice

**Special Supplement:** Opinion by CMS legal counsel on how the ADA affects your practice and what steps are necessary in your office interpretation of the law.

*By Karen Best, esq., Montgomery Little Young Campbell & McGrew, P.C.*

**NOTE:** Save this magazine supplement for future reference.

### Also In This Issue:

- Health Care Reform .....by H. G. Butler, III, M.D., President, CMS
- Bloodborne Pathogens: the \$821 Million (OSHA) Standard.....by Myron L. Treber, Human Resources specialist.
- Hawaii - its State Health Insurance Plan.....by Sandra L. Maloney, Executive Director, CMS



# Goals Vs. Performance



## **1981 Goal:**

**Operate with Insurance Professionals,  
Maintaining Physician Control**

## **1992 Assessment:**

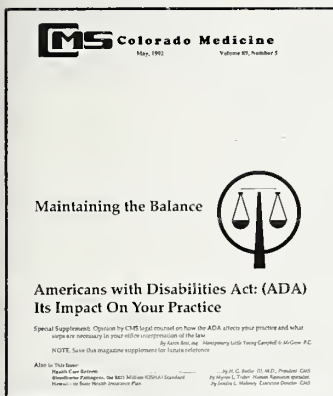
The Copic Board of Directors currently includes 10 physicians, one of whom is Chairman of the Board, plus the company's President, its General Counsel and a Certified Public Accountant. The Copic Staff is made up of 40 persons from diverse specialties within the insurance industry and 10 persons who bring with them specialized health-care experience.



## **The bottom line for Copic:**

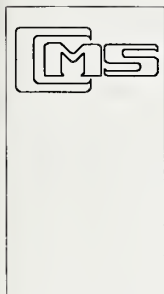
provide Colorado physicians and, indirectly, the people of the state with professional liability insurance which is affordable, equitable and fair.





## Cover Story

Much heat but little light has been generated so far on the implications of the Americans with Disabilities Act of 1990. See the special supplement in this issue for the hard facts.



## Departments

- 149 President's Letter
- 151 Executive Director's Report
- 155 The Lobby
- 161 Inside CMS
- 176 Health Care Financing
- 179 Health Department
- 183 Committee Update
- 184 New Members
- 184 Board of Directors Highlights
- 192 Medical News
- 194 Classified Advertising
- 196 Ruminations

## In This Issue...

- 149 Colorado's Health Care Reform  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 153 Participation '92: Targeting 100% Voter Involvement  
*Ben Galloway, MD*  
*Patti Brown*
- 158 Bloodborne Pathogens—The \$821 million standard  
*Myron L. Treber*
- 160 Protecting Your Assets—How good an idea is it?  
*Michael P. Thompson*  
*Assistant Managing Editor*
- 162 EMS Physician Advisors—Duties and Responsibilities  
*Stewart Greisman, DO*  
*Chairman, EMCPAC*
- 166 The Class of 1992 and the CMS in the Year 2000  
*Nancy Nelson, MD*  
*Associate Dean, University of Colorado School of Medicine*
- 169 Sunscreen Q & A  
*Ronald Tegtmeier, MD*  
*Barbara Reed, MD*  
*American Cancer Society*
- 172 Medicare Fee Schedule—The Good, Bad and Ugly  
*M. Ray Painter, MD*  
*CMS Delegate to the American Medical Association*
- 178 Six (and a half) Really Good Reasons to Blow Up the National Practitioner Data Bank  
*reprinted from Illinois Medicine*



# Colorado Medical Society

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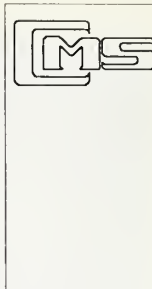
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*Harrison G. Butler, III, MD  
President, 1991-1992*

## The Colorado Medical Society and Health Care Reform

Health care reform is a much discussed topic, especially this election year. There continues to be significant legislative effort at both the state and federal levels.

In Colorado, Senate Bill 4, better known as ColoradoCare, has received the blessing of the Senate and House. There were amendments attached by the House HEWI Committee, and now the bill is in joint committee of the House and Senate to iron out the differences. I expect this to be forwarded to the Governor for his signature. This bill requires the Department of Regulatory Agencies to study the feasibility and cost savings associated with implementing a statewide health care program. It requires the department to conduct a demonstration project under which counties may develop and implement a countywide health care program for citizens within their respective counties to test some of the features of the ColoradoCare program. The bill also provides for added taxes in various forms.

An ad hoc committee of the Colorado Medical Society examined in depth, but did not endorse the bill. The CMS has endorsed a pilot project to study reform. A letter was sent to Governor Romer in support of application to the Robert Wood Johnson Foundation for a grant to fund this pilot project.

Your Medical Society, meanwhile, is taking on an ambitious project. We are conducting at least ten meetings throughout the state at which members and the Board of Directors representing

that area of the state will meet. The purpose of the meetings will be to provide input from the CMS membership on health care reform and to develop priorities. The priorities and comments will then be taken to the Board of Directors who will meet in special session to promulgate a definitive policy of the CMS on what we think should comprise a statewide health care reform package. I am also pleased that the CMS Medical Student Component is formulating its health care reform agenda. Their contribution is important and will be considered at the Board.

There is no question that the Colorado Medical Society must have a policy on this important issue in order that we be organized and credible in the ongoing negotiations. You can bet the special interest groups that are driving this discussion will be organized and **aggressive!**

It is obvious that these regional meetings are enormously important and your input is critical. The Board of Directors' policy is subject to approval of the House of Delegates and our goal is to submit this document at the Annual Meeting in September. The CMS cannot afford to have the House refer this back to committee for more work and, thus, more wasted time. Therefore, this document must be excellent in thought, content and form.

The remaining meetings scheduled are included here.

I will be looking for you at one of these regional meetings. Come prepared to discuss the issue!

### **CMS Health Care Reform Task Force statewide meetings**

#### **May 3rd Colorado Springs**

Plaza Club - 6:30 pm

#### **May 6th Pueblo**

Pueblo Country Club - 6:30 pm

#### **May 29th Durango**

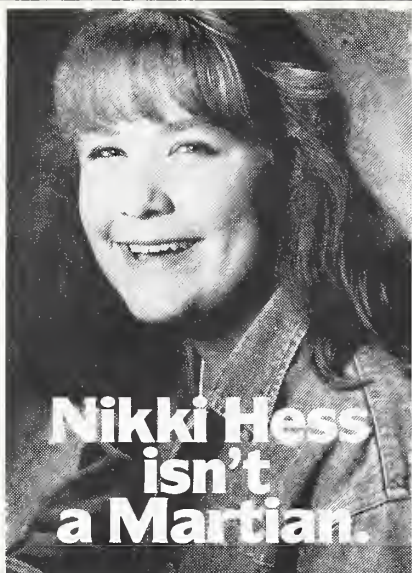
Red Lion - 6:30 pm

#### **June 3rd Fort Collins**

Marriott Hotel - 6:30 pm

#### **July 12th Grand Junction**

Hilton Hotel - 3:00 pm



But the way some kids treat her, she might as well be from another planet. Just because she has epilepsy.

You know that epilepsy doesn't make her weird. It doesn't affect her abilities, her sense of humor, or her qualities as a friend.

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Nikki is just like anyone else except for one thing. She has epilepsy. While some of your epilepsy patients need special help, they don't need walls. You can help get rid of the walls around children with epilepsy or other disabilities—and count them in.

Let's help tear down the walls around kids like Nikki. Call the Epilepsy Foundation of America, 1-800-EFA-1000 or the Epilepsy Foundation of Colorado (303) 761-2742.



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# CMS Med Fax®

**AT PRESS TIME...**

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

CMS Med Fax®

by **Montgomery Little Young Campbell and McGrew, P.C.**

legal counsel to the Colorado Medical Society

## OSHA Information In The Mail

### How to comply with regulations on bloodborne pathogens

(May 7, 1992) The first of several deadlines for compliance with new OSHA regulations on bloodborne pathogens has already passed and many physicians are concerned over their responsibilities under this law. The Colorado Medical Society has responded to the many calls on this subject.

Several consultants have offered guideline compliance publications to CMS for distribution to the membership. These publications commonly cost \$100 to \$150. CMS has chosen to assemble its own material from various sources and make it available to the membership. An outline of the OSHA regulations has already been mailed to all member physicians as part of this process.

The CMS information packet will include a summary of the OSHA Regulations on Bloodborne Pathogens, a compliance manual (used by OSHA inspectors to determine your compliance with the regulations), and a draft exposure control plan and associated forms. These last are to be used in developing your office plan for compliance.

This full information packet will be sent to physicians for \$25. This is to cover printing and postage costs. You

may mail the order form which came with your outline or FAX your credit card order to (303) 771-8657. Orders will be processed immediately upon receipt.

Remember the following deadlines when considering how to comply with these regulations:

May 5, 1992	Exposure Control Plan
June 4, 1992	Training and Record Keeping
July 6, 1992	Engineering and Work Practice Controls Personal Protective Equipment Housekeeping Vaccination Program for Hepatitis B Exposure to follow up procedures

Dr. Bonita Carson has generously offered her assistance in the development of this information and is available as a resource for further assistance in complying with the regulations. Dr. Carson can be reached at 266-3689. In addition, CMS is aware of other publications which provide information on how to comply with the OSHA regulations. For information on these resources, please call the Health Care Policy Department at (303) 779-5455 or 1-800-654-5653.

## Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate  
with the firm of Montgomery Little  
Young Campbell and McGrew, PC.

*This column is not legal advice, but is for general  
information only. For help with specific problems,  
readers should consult an attorney.*

### Medical Records

One question that continues to come up is, how much can a physician charge for copies of medical records? I now have more information for you.

Colorado has regulations and statutory provisions addressing patient records in the custody of individual health care providers. 6 CCR 1011-1, 5.3, et seq. and CRS § 25-1-802. The statute does not address the question, but the regulation does. Here's what it says about charging for patient records: "The patient or representative shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed \$10.00 for the first ten or fewer pages and \$.25 per page for every additional page. Actual postage costs also may be charged. For one or more specific classes of records or services, providers may charge additional sums upon presenting a justification therefor acceptable to the Department [of Health]."

It must be noted here, however, that the title of this section of statute is "Patient Records in Custody of Individual Health Care Providers (Outpatient Records)." Some interpret that parenthetical statement to imply that the statute applies only to hospital records which are in the custody of individual health care providers after discharge. This impression is strengthened by the fact that this section follows 6CCR 1011-1, 5.2 "Institutional Records," and repeats virtually word for word the language of section 5.2 concerning availability of the record to the patient or representative, timeliness of the act of providing the records, definition of the records and exclusion of records concerning treatment for psychiatric or psychological problems from certain types of disclosure. The statutory language concerning charges for records also allows the provider to recover actual costs of providing records, such as X-Rays, which cannot be reproduced without special equipment.

If the patient is involved in litigation, the patient can obtain his or her medical records by *subpoena duces tecum*, requiring the custodian of the records to appear at a designated location with the original medical records. The attorney requesting the record would be responsible for paying the custodian a witness and mileage fee of a few dollars, but, if the deposition is in the attorney's office, could obtain a copy of the record at the location of the deposition at little or no cost (actual copy cost). The "records deposition" procedure is more costly for both the physician, since a member of the physician's staff would likely attend the deposition, and for the patient, who is responsible for the fees and deposition costs.

The regulation allows for additional sums, if the provider presents justification to the Department of Health, a procedure which I have seen used in litigation. Commonly the physician and the requesting attorney dispute the issue of copying fees and resolve the matter without the intervention of the Department of Health.

Interestingly, both the statute and the regulation exclude the physician's "office notes" from the description of documents which must be made available to the patient.

This statute gives an idea of what is considered "reasonable" in the provision of institutional records. As these records are similar to those maintained by individual physicians, it is likely that these guidelines will be assumed to be reasonable for those physicians as well.

Physicians, on the other hand, have noted that these charges are not reflective of the actual costs of providing records in many instances. Once a staff member has to pull the record, make copies and return the record to the file, overhead costs can easily exceed the named amounts, which are part of a statute adopted in 1978. In addition, physicians have noted that other professionals, such as attorneys, have been known to charge far more for records than the minimal amount mentioned in the statute.

On the other hand, one attorney who commonly represents indigent clients points out that any charge a physician makes for a record requested by an attorney will be passed on to the client. This means that trying to compensate for the perceived threat of malpractice litigation could easily backfire, costing the *patient*, not the attorney.



## Claims to be denied for failure to include Unique Physician Identification Number (UPIN)

*by Edie Register, Director  
Health Care Financing  
Colorado Medical Society*

(May 6, 1992) While in the offices of Blue Crose/Blue Shield of Colorado I heard some alarming news. In the claims area, they were preparing to deny some 1,200 claims for laboratory services performed in the physician's office.

The basis of these denials was failure to include the Unique Provider Identification Number (UPIN) on line 17a of the HCFA-1500. Physicians were informed of this requirement in the *Medicare Bulletin* dated March 30, 1992. The only services denied should be the lab services.

If you experience a denial of this sort, just resubmit the claim for lab services and make sure to include your UPIN.

## "Your Right to Make Health Care Decisions"

The Colorado Hospital Association has announced that a pamphlet by this title is available from Hospital Shared Services, Inc. In addition, CHA has produced an audio tape of the same information in English only. The pamphlet is in English or Spanish. They will be revised to include the latest changes in the law regarding patient's rights to make decisions during the next few months.

To order pamphlets, call HSS at (303) 455-1420. To order the audio tape, call CHA at 758-1630.

## Denver Medical Library to Offer Online Information

(May 7, 1992) The Denver Medical Library has announced a new service called PaperChase, which will be available to CMS members. PaperChase gives anyone with a computer and modem access to MEDLINE, the world's largest biomedical data base.

PaperChase eliminates many of the problems associated with obtaining up to date medical information. It lets you use your own search terms and translates your words into the exact search terms you should use for optimum access to the data base. It is designed to keep you abreast of the latest developments and provide information fast when you need it. PaperChase is available 365 days per year, 24 hours per day.

This Denver Medical Library program will offer institutional passwords, including unlimited access to MEDLINE at a reduced rate and remote access from your home or office. The charge for this service will be \$150 per year. For more information, contact Mary DeMund at the Denver Medical Library, (303) 839-6670.

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

### **Colorado Health Care Association**

Nursing Home Week

May 10-16, 1992

Colorado

Arlene Miles (303) 861-8228

### **Colorado Department of Health**

Domestic Violence for Health Care Providers  
Gunnison

May 15, 1992

Western Area AHEC 434-5474

# CMS Med Fax

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## **World Congress on Healthcare**

World Telecommunications Conference (live broadcast)  
from New York by satellite

May 20, 21, 1991

Mike Dulligan (800) 879-3857

## **American Academy of Pediatrics**

Perinatal Pediatrics Conference

Kauai, Hawaii

May 21-24, 1992

L. Joseph Butterfield, MD (303) 881-8509

## **Global Congress on Patient Cards and**

## **Computerisation of Health Records**

Cards, Databases and Medical Communication

Berlin, Germany

May 25-28, 1992

(617) 964-3923

## **Rush-Presbyterian-St. Luke's Medical Center**

Cytokines and Transplantation

Chicago, IL

May 30, 1992

Suzanne Buss (312) 942-6242

## **American Medical Association**

Financial Strategies for Retirement

Denver, Colorado

June 5, 1992

(312) 419-5042

## **American Medical Association**

Successful Money Management

Denver, Colorado

June 6, 1992

(312) 419-5042

## **Medical Education Resources**

Coronary Heart Disease Update

Cape Cod, MA

June 11-13, 1992

(303) 798-9682 or 1-800-421-3756

## **Colorado Department of Health**

Domestic Violence for Health Care Providers

Boulder

June 12, 1992

Centennial AHEC 351-0755

## **Medical Education Resources**

Advances in Vascular Diseases

Anaheim CA

June 26-27, 1992

(303) 798-9682 or 1-800-421-3756

## **Colorado Neurological Institute**

9th International Workshop for the Study of Vascular  
Anomalies

Westin Hotel, Denver

July 1-3, 1992

(303) 798-9682 or 800-421-3756

## **Colorado Assist Alliance**

How You Can Help Your Patients Stop Smoking

Grand Junction

June 19, 1992

Phyllis Harris, (303) 242-0731

## **Medical Education Resources**

Advances in Vascular Diseases

Hilton Head Island SC

July 10-11, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

Asthma and Allergy in the 1990s

Jackson Hole WY

July 24-25, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

Coronary Heart Disease Update

Lake Tahoe NV

July 31-August 1 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

Neurology for the Non-Neurologist

Vail, Colorado

August 14-16, 1992

Stephen E Mattingly (303) 798-9682 or 800-421-3756

## **Assault Survivors Assistance Program/Redirecting**

**Sexual Aggression**

Sexual Trauma: A Balanced Approach

Vail, Colorado

August 28, 29, 1992







Sandra L. Maloney  
Executive Director

## Hawaii: sandy beaches, tropical breezes and...“SHIP”

*“The fee scale is based upon the patient’s ability to pay.”*

The health care system of Hawaii recently has generated a great deal of discussion. Several of you have asked that I provide information regarding this plan. This information may be timely, especially since we are discussing the merits of the Colorado health care system. “Reform” has recently become an overused “buzz” word. We find it in the media, state legislatures, the United States Congress and yes, even at CMS. Webster’s defines reform in many ways, one of which is “to amend or improve by change of form or removal of faults or abuses.” Appears to carry a negative connotation, does it not? In Hawaii, it seems that reform made a positive change.

The Prepaid Health Care Act of Hawaii was enacted in 1974. This legislation established minimum standards of health care coverage for the vast majority of workers in the state. It mandated that employers with one or more employees (defined as one who works at least 20 hours per week and has been with the employer for four weeks) provide health care coverage for the employees. Two plans are available: a fee-for-service plan and a health maintenance plan. Costs are shared between the employer, who is required to pay at least 50% of the cost of the premiums, and the employee, who must contribute the balance, but in no case more than 1.5% of an employee’s monthly wages. The minimum standards are as follows:

- Hospital inpatient care of at least 120 days per year.
- Hospital outpatient care.
- Surgical benefits, including anesthesiologist services.
- Necessary home, office and hospital visits by a physician.
- Intensive medical care while hospitalized
- Medical or surgical consultations while confined
- Diagnostic laboratory services, x-rays and radio-therapeutic services
- Maternity care services.



Employers who fail to abide by this law are subject to fines, or may be required to repay the employee any health care costs incurred during the period in which the employer failed to provide coverage. The most severe penalty for non-compliance is an injunction levied against the employer prohibiting the company from doing business in the state. (A “play or else” system!)

*(Continued on following page)*

# Hawaii:

(Continued)



In 1989, Hawaii modified the original legislation by providing coverage for those who were not covered under the original Act. This affected about 5% of the state's population. This new program, commonly called "SHIP" (State Health Insurance Program) is directed at primary care. There is an allowance for twelve physician visits per year.

Inpatient care is limited to no more than five days a year with a \$2500 limit per person. Preventive services such as immunization for children, health screenings, lab, and other diagnostic services are covered. Elective surgery is not covered.

Eligibility requirements for SHIP are that the person must be a resident of Hawaii and the person's gross family income must be less than 300% of the federal poverty level for Hawaii at the time of application. Those individuals who are below the poverty level and who are unable to afford private insurance, but with too much money or too many assets to be eligible for Medicaid (the "working poor") are also covered. Medicaid is not included in the Prepaid Health Plan; it is administered separately.

The fee scale is based upon the

patient's ability to pay. Insurance carriers directly bill the patient. Currently, only two insurance carriers (Kaiser Permanente and Blue Cross Blue Shield) are participating in the program.

As of 1991, the Prepaid Health Care Act, SHIP, and Medicaid covered all but about 2% of the population. 98% of the people were provided varying types of health care benefits.

They have the same philosophy as CMS regarding universal access, i.e., there should be a state-based approach to health care reform rather than universal health care at the national level.

I am hopeful that this information provides some insight as to how the Hawaii program operates. I would be happy to provide additional information to any of you who may want more detail.



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# Participation '92

## Targeting 100% Voter Involvement



The past few weeks have witnessed some rather dramatic events in the history of Colorado Politics. Colorado's Senior U.S. Senator, Democrat Timothy Wirth, seven months before the general election, announced that he would not be a candidate for re-election. At least for now, this announcement ends a career in politics spanning 18 years representing Colorado in the U.S. Congress.

Mr. Wirth joins approximately fifty incumbent members of Congress who have opted not to seek re-election. Senator Wirth cites his increasing frustration with the manner in which the Senate conducts its business as a prime factor contributing to his decision. He also cites political paralysis, campaign reform, lack of long-term policy development and other factors which have dampened his enthusiasm and heightened his frustration with his present position.

Participation '92 will allow all of us in medicine to re-evaluate our relationships with politics and the type of government we have the right and privilege to choose. We can all sit on the sidelines and continue to complain about government failure or we can become proactive. We can commit our time, talent and/or treasure in the political process to effect change that we think necessary.

Participation '92 is an effort within organized medicine to educate and stimulate participation at the grass roots level by members of the medical community. This can best be achieved

by active participation in campaigns within either party for the state legislature and the U.S. Congress this summer and fall as the campaigns prepare for the November elections.

Recently, while attending a dinner honoring a leader in the cable TV industry, I had the privilege of hearing Lee Greenwood, a popular country music singer, sing "I Am Proud To Be An American." The audience responded a thousand strong by standing and emotionally joining Mr. Greenwood in singing the final verses. I was awed by the tremendous positive emotion this audience expressed for our country during this emotional testimony.

We, as a country, and medicine collectively, need to transform this emotional energy into accepting the challenge. Yes, we have leadership problems and our institutions of government are not functioning as we would always like but we, as a people, have the energy, desire and commitment to change our direction. Participation '92 is a format allowing all of us to get involved, to restructure our priorities, and to effect change that we, as a profession, deem necessary.

In the coming months we will be providing information relating to the effects of re-districting state and federal legislative districts, candidates and their positions on issues. The Medical Society is available to answer questions and provide guidance for your Participation in 1992. An important first step is to make sure you are registered to vote.



*Ben Galloway, MD  
Chairman, Participation '92*



# Participation '92

## Targeting 100% Voter Involvement



*Patti Brown,  
CMS Auxiliary Legislative Affairs  
Chairman, 1991-1992  
Co-Chairman, CMSA Participation '92*

Players win, victims lose and the time is now for medicine to become a player. On November 3, 1992, Americans will go to the polls to elect a President, 35 U.S. Senators, 435 Representatives, 12 Governors and thousands of state and local officials. These *elected* lawmakers on the Federal, State and Local levels will continue in their efforts to legislate the future of medicine. Approximately 11% of a lawmaker's constituents decide who is elected. "Unless the people who make up medicine work to develop their political and legislative skills as constituents, control of the profession's future will slowly slip out of medicine's grasp."<sup>1</sup>

Clearly, some kind of Health Care Reform is looming on the horizon. In many ways it has already been evolving with DRG's, RBRVS, etc. Will YOU be a *Player* in the process or its *Victim*? In today's highly competitive political arena, where many special interest groups present their cases to the lawmakers, *Medicine Must Make Its Unified Voice Heard*. What better group is there to work with all the interested players in designing a quality health care system than physicians and physicians' families?

How can physicians and their families become involved in the legislative process and begin to develop a productive relationship with their lawmakers? Here are a few suggestions:

1. Are you registered to vote?  
July 17—Last day to register to vote in the Primary Election  
October 9—Last day to register to vote in the General Election
2. Offer to work on a Political Campaign of your choice, local or national or both. Interview prospective candidates and then give of your time on the telephones or stuffing envelopes, etc.

3. Attend the County, State and National Democratic or Republican Assemblies or Conventions as a delegate. Use your expertise to help shape policy. Remember, if you don't speak for yourself, someone else will speak for you.
4. Invite the incumbents and opponents to speak in your Component Medical Society meetings. Discuss the issues (Don't lecture) with the candidates and find out their stands. Remember to say thank you for a job well done by a Legislator. We all enjoy positive recognition.
5. Attend Political Functions and Fund-raisers. Introduce yourself! It may take at least 4 introductions to be recognized.
6. Join COMPAC—The Colorado Medical Political Action Committee is a voluntary, non-profit, bi-partisan committee formed to provide monetary support to state legislative candidates. Candidates are interviewed and monetary support is given to those candidates favorable to the goals of organized medicine.
7. Make political contributions to the candidates of your choice. Every lawmaker's #1 priority is fund raising! A \$200 contribution is the minimal amount that is required to be reported to the government. All lawmakers have these contributors' lists and use them!
8. Host a Candidate Fundraiser in your home!
9. Mini-Internship Program—Volunteer to work with lawmakers or their staff and share a hands-on view of the practice of medicine.
10. Remember to VOTE:  
August 11—Primary Election  
November 3—General Election

<sup>1</sup> Developing Constituent Skills, *Chicago, The American Medical Association 1990*

*"You don't get something for nothing," is doubly true in politics. I hope each and every one of you will give of yourselves in this election year. If you need further information or help with implementing any of these suggestions, contact me (794-1023) or the CMS Government Relations office (779-5455).*

*By Working Together—We Can Make A Difference*



Alan D. Rapp, MD, Chairman  
CMS Council on Legislation  
with  
Sue Ellen Quam, Director  
Department of Government Relations  
and  
Lorraine Koehn  
Program Manager/Lobbyist

The legislative session is nearing the end. Adjournment *sine die* is scheduled for May 6. The legislature still has much to do in these last days. School finance funding remains unresolved and there is uncertainty as to what impact this will have on the rest of our state's budget. Governor Romer, in his State of the State speech in January, threatened to veto the entire budget bill if schools were not adequately funded.

Physicians and patients still have major legislation left to work on during this short time period. We have outlined two of our biggest remaining legislative efforts.

The State Auditor's Report on the Health Data Commission was released last week. It states that the Commission should consider stopping the collection of data directly from hospitals and instead get the information from the Colorado Hospital Association. The audit also says the health data commission has not clearly defined its mission, does not have a process to systematically plan its activities, does not keep track of its users or know if the information it provides is useful, and does not have information to evaluate whether it is accomplishing its purpose. There may be legislation to address these issues yet this session. Stay tuned.

**HB 1306, CONCERNING THE DELIVERY OF SERVICES PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT" THROUGH MANAGED CARE (Coffman):** The Colorado Medical Society believes that HB 1306 embodies several very positive principles which should increase the cost effectiveness and medical appropriateness of the Colorado Medicaid Program. These include: (1) implementation of man-

aged care principles; (2) mandatory selection of a primary care physician; (3) a feasibility study for capitated mental health care, and (4) capitation for other health services.

Section 26-404(b)(1) of the bill mandates that the Department of Social Services pay the lower of Medicare/Medicaid when individuals have dual eligibility. This section is of major concern to the society because we believe that the lower reimbursement rate will seriously impact access to medical care, especially for nursing home patients.

Although the differences in payment may appear minimal if a health care provider sees only a limited number of Medicare/Medicaid patients, the impact on providers with a large Medicare/Medicaid clientele, such as primary care physicians and gerontologists, will be devastating. A good example is the basic visit code for nursing home visits, 99311 (page 4 of the summary) Medicare pays 80% of the usual and customary fee of \$27.15 which equals \$21.72. Medicaid pays only \$9.80.

This section of HB 1306 will heighten the crisis that already exists in finding qualified attending physicians for long-term care patients. Qualified attending physicians are needed, particularly in this setting to assure that the many available services, including hospitalization are utilized appropriately. Not only will this impact primary care physicians but it will also have a negative effect on specialty care physicians.

The efforts of Representative Coffman to refine the Medicaid program via HB 1306 are greatly appreciated, but we believe that CMS

*Nearing the end of the legislative session.*

*"CMS would be acting irresponsibly if we failed."*

would be acting irresponsibly if we failed to bring the problems with this section of the bill (and our reasons for opposition) to the Colorado legislature.

A summary of Medicare and Medicaid codes and the allowable costs for each program was prepared by staff of the CMS Department of Health Care Financing. This summary paints an excellent picture of the impact that HB 1306 will have on reimbursement levels for physicians who treat Medicare/Medicaid patients. The paper was presented to Representative Coffman, members of the JBC and the Medicaid Division of the Department of Social Services.

The Colorado Medical Society, the Colorado Academy of Family Physicians, the Denver Medical Society and the Colorado Chapter of the American College of Emergency Physicians support the *amended SB92-3 - CONCERNING PATIENT AUTONOMY IN REGARD TO THE MAKING OF MEDICAL TREATMENT DECISIONS* (Senators Wham and Allison and Representatives Fish, Agler and Killian): We believe that the bill supports the concept of respecting and promoting patient autonomy while fostering the well-being of the patient. Individual values and preferences differ tremendously regarding the extent to which the preservation and quality of life should be pursued. The groups believe these differences should be respected.

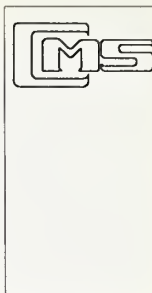
SB92-3 has passed the Senate and will be voted upon on April 16, 1992 in the House Judiciary Committee. Thank you for responding to the Alerts on this bill. Strengthening patient autonomy by use of advance medical directives and acknowledging the reliance on family members and close friends when the

patient's wishes are known, but not in writing, has been a patient advocacy goal for CMS for many years. Senators Wham, Allison, Johnson, Gallagher and Wattenberg worked very hard to amend and pass this legislation. Representatives who are working hard for the passage of this bill are: Fish (House sponsor), Kerns, Killian and Grant. Please thank them for their hard work.

What the amended bill does: The bill recognizes the right of an adult to accept or reject medical treatment and artificial nourishment and hydration. It affirms the patient's autonomy in accepting or rejecting medical treatment, including the making of medical treatment decisions through an appointed agent under a medical durable power of attorney. The bill does not intend to encourage or discourage any particular medical treatment or to interfere with or affect any method of religious or spiritual healing otherwise permitted by law. It simply reaffirms that a patient's wishes for continuing or ending treatment be respected and implemented. If a health care provider or facility does not wish to comply with an agent's medical treatment decision based on differences regarding moral convictions or religious beliefs they shall provide for the prompt transfer of the patient to another provider or facility. That way neither the patient's or the health care provider's religious or moral beliefs will be compromised.

The amended SB92-3 has three major sections. The first section recognizes that each adult has the right to establish an advance medical directive. An advance medical directive is a document that enables competent persons to exercise their right to direct medical treatments in the event that they lose their decision making





capacity. We believe that the use of advance directives assures individuals that their interests will be promoted in the event that they become incompetent. The bill allows for the individual to designate an individual to be his/her agent (medical decision maker) or to specify in writing what sorts of medical treatment a patient would or would not want. *An advance medical directive is different from a living will. A living will is a document you sign telling your doctor not to use artificial life support measures if you become terminally ill. Your living will does not go into effect until two doctors agree in writing that you have a terminal condition, as defined by Colorado law.*

The second section recognizes the use of proxy decision-makers in the event the patient does not have an advance medical directive. It is estimated that only 5-10% of our population has implemented an advance medical directive. The bulk of our population relies on close family members and friends to speak for them once they become unable to speak for themselves. This section acknowledges what currently takes place under these circumstances. Close family members and friends will be asked to relay the patient's wishes in regard to medical treatment decisions. Only these people should be responsible for decisions that profoundly affect the patient's well-being. In today's world, family sometimes includes persons with whom the patient is closely associated. The bill acknowledges this by including any close friend of the patient. Family members and close friends best know the patient's philosophical, religious and moral views; the patient's values about life and the way it should be lived; and the patient's attitudes toward

sickness, suffering, medical procedures and death.

The physician, other health care workers and facilities will be afforded legal protection for following those expressed wishes. If the close family members and friends cannot reach a consensus the decision may be forwarded to the courts.

The third section allows people to sign directives saying that they do not want to receive cardiopulmonary resuscitation both before and after they enter an institutionalized setting. It would also allow their agent or proxy to speak on their behalf regarding the use of CPR. In the absence of one of these "DNR" orders, it would be presumed that a person would want CPR. Health care providers, including paramedics and emergency medical technicians would be legally protected when following such directives.

CMS physicians and staff have spent the last two years working on advance medical directives legislation which would advance patient autonomy. We have worked with many other like minded associations and individuals. We would like to publicly thank the following individuals and groups who have helped pass the bill to this point in the legislative process. Susan Fox Buchanan, Esq.; Dorothy Hillibrand; David Murphy, MD; the following CMS/DMS/ACEP physicians: Fred Abrams, Don Parsons, John Sbarbaro, Mary Jo Jacobs, Meredith "Bud" Miller, Carla Murphy, John Muth, Gary Pons, Stewart Greisman; Colorado Hospital Association; Colorado Health Care Association; the Senior Lobby, and AARP.

*"We believe that the use of advance directives assures individuals that their interests will be promoted"*

# Bloodborne Pathogens:

*The \$821 Million Standard®*

*Editor's Note: Much has been said and written about compliance with the new OSHA guidelines on transmission of blood-borne pathogens. Approaching the issue from a different angle, however, is personnel manager Myron L. Treber. Mr. Treber does consulting work for Copic Insurance Company and he says that a thorough examination of personnel practices may reduce the burden of compliance with these standards.*

*"This is a good time to re-evaluate all the jobs in your practice..."*

**Y**es, you read correctly. \$821 million is what agency experts for Occupational Safety and Health Administration (OSHA) estimate employers will spend to implement and comply with OSHA's latest standard, *Occupational Exposure to Bloodborne Pathogens*, which was summarized in last month's issue of *Colorado Medicine*.

**I**n reviewing this new standard, it occurred to me that many of you may already have several elements in place that will help you comply with the intent of the law. That's the good news. In order to be in complete compliance, however, you must now assure that you and your employees follow the letter, as well as the intent of the law. As I discussed this standard with my wife, who is responsible for safety in a large manufacturing plant, she shared this scenario with me. In accordance with OSHA regulations, she prepared an emergency evacuation plan for her plant. The OSHA inspector arrived to review the plan. After thoroughly going over it, he turned to her and said, "It looks fine except for one thing. You didn't consider wind direction during evacuation." You see, they leave no stone unturned. OSHA expects complete compliance, and their regulations and standards leave very little (if any) room for employer discretion...and that's the bad news! Let's look at the provisions for this Standard from a human resource management perspective. The Exposure Control Plan (to be completed on or before May 5, 1992) should be designed and written to eliminate or minimize employee

exposure. You probably already have something in place which at least minimizes employee exposure. Now you need to formalize it, put it in writing and make sure it complies with the provisions of the Standard [see para. (c)(ii)(iv)]. Part of your Exposure Control Plan requires preparation of an **EXPOSURE DETERMINATION**. This is a document which requires three lists [see para. (c)(2)]. This is a good time to re-evaluate all the jobs in your practice, because to comply you will need to know whether all or just some of your employees within a certain job classification have occupational exposure.

**I**f your evaluation indicates that only on rare occasion does a person have exposure, you may want to consider removing those duties from his/her job, thus eliminating exposure. The fewer employees you have with exposure, the easier it will be for you to assure compliance with this standard. Furthermore, if the job has exposure, you should make compliance with this standard a requirement of the job, because now you **must assure that your employees follow the rules of this standard**.

**H**ere are some other reasons for re-evaluating your jobs. Without a well-defined job description, it will be difficult for you to comply with many elements of the Information and Training requirement. For example, paragraph (S)(2)(ix)(C) states that, "A progression of work activities shall be assigned as techniques are learned and





by Myron L. Treber

proficiency is developed." Re-evaluation of jobs will help you identify the progression of work activities and develop standards of performance for those activities, allowing you to quantify when proficiency is developed.

**A**nother reason is that in order to assure compliance by your employees, they must clearly understand their duties and the importance of performing their tasks in compliance with this Standard. They must also understand the consequences if they don't comply with the controls you have in place; that is, what, if any discipline will they receive? The consequences for non-compliance with OSHA regulations can be rather severe for an employer; therefore, I would suggest relatively severe discipline for an employee who fails to comply.

**T**he impending Americans With Disabilities Act (ADA) is another reason for re-evaluating your jobs. It would be wise to include specific physical, mental and skills requirements of the job to assure employees can perform the required duties. Remember, the Exposure Control Plan should be designed to eliminate or minimize exposure. Depending upon the level of his or her disability, an employee could expose you to unnecessary risk, even if you make reasonable accommodations.

**M**ethods of Compliance (to take effect on July 5, 1992) generally has to do with Universal Precautions. Again, you probably have procedures in place which address rather comprehensive

infection control. But now you need to do it "by the book." That is, OSHA now requires compliance with nearly 100 controls in this area alone; as an employer, you must ensure that your employees comply with each of them! Like your *Exposure Control Plan*, your Methods of Compliance should be in writing; and you can use the Standard's list [para. (d)(2), *Engineering and Work Practice Controls*] as your guide.

**Y**our *Exposure Control Plan* and Methods of Compliance are critical to another provision of this Standard. Information and Training (to take effect on or before June 4, 1992) requires you to provide training, consisting of numerous components as outlined in para. (g)(2)(vii) through (ix). In addition to the actual training, compliance with this provision will require an outline and schedule be made available in the event of an OSHA audit.

**F**inally, there is the Recordkeeping provision (to take effect on or before June 4, 1992). OSHA has clearly indicated its recordkeeping requirements, and you must assure that your personnel files are updated and maintained accordingly. Obviously, in the space available, one cannot cover all the requirements of such a sweeping standard. Even so, you can see it calls for a great deal of documentation and recordkeeping to which you may not be accustomed. It is not something we can take lightly. OSHA intends to introduce special enforcement procedures for the Standard and may slap violators with the strictest penalties allowed by law.

*"It is not something we can take lightly."*

# P

# rotecting Your Assets

## *How to defend yourself against unfair seizure of assets.*

It's a game in which the rules aren't always crystal clear and the stakes are high. You'll want some hard information before you decide to play.

Asset protection is a way to shield your property from hazards. Those hazards could involve lawsuits, divorce, taxation and more. You've heard the horror stories. A physician is named with a dozen other parties in a lawsuit. Even if you're later found blameless, you still have to deal with legal costs and time out of the office, not to mention your own stress.

Malpractice litigation is only one of the sharks after your assets. One physician signed over most of his property to his wife. It sounded good. Avoid estate taxes, probate court and keep it off limits to attachment by courts, all at the same time. The flaw was revealed when his wife filed for divorce the next week.

Asset protection strategies are no less hazardous to the unwary than leaving yourself bare. One popular strategy involves placing assets in an "offshore trust." The trust, headquartered in a small island nation somewhere, owns the assets. The physician retains the rights and income from them, etc. Local laws protect the assets from U. S. Court proceedings, at least enough so that plaintiff's attorneys will

often discuss settlement rather than pursue expensive litigation to get at them.

There are dangers, though. The timing or circumstances of the transfer of the assets to the trust could open you to charges of "fraudulent conveyance." This is especially true if the court believes your sole aim was to deny compensation to a truly injured patient. It's no substitute for malpractice insurance. It should also have other value, such as avoidance of inheritance taxes, income for your children, college tuition, and the like. The expense and difficulty of setting it up should be considered.

Besides the offshore trust, there are dozens of other trusts, deeds, gifts, wills, and other techniques to protect your assets from unfair seizure. To help you chart your way through these dangerous shoals, the Colorado Medical Society is sponsoring *Asset Protection in the '90s: Prescriptions for Your Financial Health and Well Being*. This day long workshop (June 4—9 am to 5 pm) includes lunch and involves top-notch experts giving you advice on everything from estate and financial planning to keeping your income out of the hands of the IRS. Call (303) 779-5455 or 1-800-654-5653, ext. 430 for more information.

*The Colorado Medical Society joins the American Medical Association in honoring the following physicians for their commitment to excellence in medical practice as demonstrated by their participation in Continuing Medical Education.*

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# **The Americans With Disabilities Act: Its Impact On Your Practice**

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Colorado Medical Society

A Special Supplement  
to

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**May, 1992**







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To the members of the Colorado Medical Society:

At its March, 1992 Interim Meeting, the Colorado Medical Society House of Delegates resolved to obtain a legal opinion concerning the "Americans With Disabilities Act, 1990" which became the "Final Rule" on July 26, 1991. The Final Rule became effective on January 26, 1992.

The House of Delegates directed the CMS staff to distribute this information in the most expeditious manner.

Here, then, is the opinion from the CMS legal counsel. CMS hopes this will be helpful to each physician in determining the impact of this rule on individual practice modalities prior to court tests or judicial interpretation.

I urge each member to read this document carefully upon receipt and, if you have questions, contact your own legal counsel. This is not a matter to be handled lightly. As the author of this opinion, Ms. Karen Best, Esq., states, the act provides comprehensive rules and "its provisions cannot be ignored."

Respectfully,

H. G. Butler, III, M.D.  
President

# The Americans With Disabilities Act: Its Impact On Your Practice

By: *Karen B. Best, Esq., an associate with the law firm  
Montgomery Little Young Campbell & McGrew, P.C.*

## Introduction

The Americans with Disabilities Act of 1990 (the "ADA") is comprehensive legislation aimed at eliminating discrimination against individuals with disabilities and bringing those people into the economic and social mainstream of American life.<sup>1</sup> It establishes standards against which conduct will be measured to determine whether discrimination has occurred, and allows individuals and the federal government to enforce those standards.

The ADA contains provisions dealing with employment (Title I), public services (Title II), public accommodations and devices operated by private entities (Title III), and telecommunications (Title IV).

Title III has the most direct impact upon the provision of medical services to individuals with disabilities by private hospitals and health care professionals. This article will focus on that portion of the ADA as well as on the interpretive language of the Final Rule issued by the Department of Justice, Office of the Attorney General, and the Report of the Senate Committee on Labor and Human Resources.<sup>2</sup>

## Title III Public Accommodations and

### Services Operated by Private Entities.

Title III prohibits discriminatory practices by public accommodations and commercial facilities operated by private entities, whose operations affect commerce. The general rule is that: No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.<sup>3</sup>

### Definition of Public Accommodations:

Under the ADA, pharmacies, professional offices of health care providers, hospitals and other similar service establishments are included within the definition of a public accommodation, if the operation of the entity affects commerce.<sup>4</sup> An effect on commerce exists if there is travel, trade, traffic, commerce, transportation or communication among several States, between any foreign country or any territory or possession and any State, or between points in the same State through another State or foreign country.<sup>5</sup> Thus, if the hospital or the medical practice serves patients from different states, if

supplies or equipment are purchased from other states and transported across state lines, or if the operation of the entity involves communication across state lines, the activity may be found to affect commerce, making the provisions of the Act applicable to the entity. The ADA and the Final Rule will have extremely broad application.

Establishments operated by Federal, State, and local governments, such as Denver General Hospital and University Hospital, are not covered by Title III<sup>6</sup>, although those entities would be governed by similar provisions in Title II of the Act.<sup>7</sup> The receipt of government assistance by a private entity does not by itself preclude a facility from being considered a place of public accommodation.<sup>8</sup> In other words, receipt of government assistance does not transform a private entity into a public entity for purposes of the Act, such that the entity would not be governed by the provisions of Title III. Thus, a medical practice which receives Medicare or Medicaid payments may nonetheless fall within the provisions of Title III, if the physician, practice, or hospital affects commerce.<sup>9</sup> A question not answered by the ADA itself is whether the receipt of Federal

<sup>1</sup> 42 U.S.C. 12101. et seq. (hereafter referred to by ADA section).

<sup>2</sup> 28 C.F.R. Part 36, Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Department of Justice, Office of the Attorney General, Final Rule issued July 26, 1991 (hereafter the "Final Rule"); Report 101-116, Senate Committee on Labor and Human Resources (hereafter "Report 101-116")

<sup>3</sup> ADA, Section 302(a).

<sup>4</sup> ADA, Section 301 (7) (F).

<sup>5</sup> ADA, Section 301 (I).

<sup>6</sup> 42 USC 12181, Section 301 (6).

<sup>7</sup> ADA, Section 201.

<sup>8</sup> Final Rule, § 36.209.



money alone (payments traveling across state lines) satisfies the "affecting commerce" requirement, such that any medical practice receiving Medicaid payments or other Federal financial assistance would fall within the provisions of the ADA. That answer may lie in the Rehabilitation Act of 1973 which already prohibits Federal agencies and recipients of Federal financial assistance from discriminating against persons with disabilities.<sup>9</sup> If a physician and his or her practice do not "affect commerce," then the physician is not considered a "public accommodation" and the office is not considered a "place of public accommodation," subject to the prohibitions against discrimination. The Act only applies to public accommodations. To the extent this article refers to physicians and their offices, or hospitals, it is assumed that the entities referred to constitute public accommodations.

**Definition of Disability:** A "disability" is defined as (1) a physical or mental impairment that substantially limits one or more of the major life activities of the individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment.

(a) **Physical or Mental Impairment:** The first group includes individuals with (A) physiological disorders or conditions, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; blood and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic

brain syndrome, emotional or mental illness, and specific learning disabilities.<sup>10</sup>

The Act does not contain an inclusive list of all conditions, diseases or infections that would constitute physical or mental impairments. It would, however, include: orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, infection with HIV, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, drug addiction, and alcoholism.<sup>12</sup>

The term "physical or mental impairment" does not include simple physical characteristics such as eye or hair color, height, or environmental, cultural or economic disadvantages such as poverty or a prison record. The ADA does not prohibit discrimination based on an individual's current illegal use of drugs.<sup>13</sup> Age, homosexuality, transvestism and other sexual disorders are not considered disabilities within the Act or the Final Rule.<sup>14</sup>

The physical or mental impairment is not considered a disability unless it results in a substantial limitation of one or more major life activities. Those activities include: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.<sup>15</sup> A person with HIV is considered disabled under this section of the definition.<sup>16</sup>

(b) **A Record of Such an Impairment:** The second group includes individuals who have a history of, or who have been misclassified as having a mental or physical impairment that substan-

tially limits one or more major life activities. This provision protects those who, for example, have a history of, but have recovered from, mental or emotional illness, heart disease or cancer, and those who have been misclassified as mentally retarded.

(c) **Being Regarded as Having Such an Impairment:** The third area deals with attitudes and perceptions of others toward individuals who do not actually suffer from a physical or mental impairment that substantially limits life activities. Congress recognizes that negative reactions toward people with impairments (which would not otherwise substantially limit their functioning) may substantially limit that person's ability to function in the mainstream of society.<sup>17</sup> Thus, a person who is not allowed into a public accommodation because of the myths, fears, and stereotypes associated with the person's disability, would be included in the third group, whether or not the person's physical or mental condition would be considered a disability under the first or second test in the definition.

Severe burn victims fall in this category, as do those with hearing aids. People who look different - the "Hunchback of Notre Dame" - cannot be denied service because of the potentially negative reactions of others also seeking the service. Those people are protected from discrimination

**Definition of Discrimination:** What is "discrimination?" Discrimination includes: (1) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disabilities from fully and equally enjoying any goods, services, facilities, privileges, advan-

<sup>9</sup> Report 101-116, at p.59.

<sup>10</sup> Report 101-116, at p.58.

<sup>11</sup> 42 USC 12102(2); ADA, Section 3(2)

<sup>12</sup> Report 101-116, at p. 22.

<sup>13</sup> ADA, Section 510; Final Rule, Section 36.209.

<sup>14</sup> Final Rule, § 36.104. Other conditions excluded from the definition of a disability in the Final Rule include: transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from current illegal use of drugs.

<sup>15</sup> Report 101-116,

<sup>16</sup> Report 101-116 at 22, citing U.S. Department of Justice, "Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals," September 27, 1988, at 9-11.

tages, and accommodations (referred to as “benefits”), unless the criteria can be shown to be necessary for the provision of the benefits being offered; (2) a failure to make reasonable modifications in policies, practices or procedures, unless the entity can demonstrate that making the modifications would fundamentally alter the nature of the benefits; (3) a failure to take steps necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking the steps would fundamentally alter the nature of the benefits being offered or would result in an undue burden; (4) a failure to remove architectural barriers, and communication barriers in existing facilities, where such removal is readily achievable; and (5) where an entity can demonstrate that the removal of a barrier under clause (4) is not readily achievable, a failure to make such benefits available through alternative methods if such methods are readily achievable.<sup>18</sup>

Generally, public accommodations must take steps to ensure that an individual with a disability will not be excluded, denied services, segregated or otherwise treated differently from other individuals because of the use of inappropriate or ineffective auxiliary aids.

Benefits must be offered to the disabled in the most integrated setting appropriate to the needs of the disabled individual.<sup>19</sup> It would be discriminatory to require individuals with disabilities to use a separate waiting area, in order to segregate those individuals from other patients.

Individuals with disabilities may not be denied participation in mainstream activities due to the existence of separate or different programs or activities designed for the disabled.<sup>21</sup>

Moreover, benefits may not be denied because of a known disability of an individual with whom the individual or entity seeking benefits is known to have a relationship or association.<sup>22</sup> Thus, it may be discriminatory to exclude a person because he or she is related to or a friend of an HIV positive individual.

(a) **Patient Screening:** Have physicians been stripped of their ability to choose who they will and will not treat? Not necessarily; however, under the Act a physician cannot legally screen out patients on the basis of a disability. For example, an orthopedic surgeon may violate the Act if the surgeon refuses to treat a patient with epilepsy who needs orthopedic services, if the refusal to treat is based solely upon the fact that the patient has epilepsy. Of course, an orthopedic surgeon may refuse to treat an individual with epilepsy, if the patient is seeking treatment for a neurological disorder.

Additionally, a health care provider would not be required to treat an individual with a disability if the individual poses a direct threat to the health or safety of others.<sup>23</sup> A “direct threat” is defined as a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

Thus, it may be a violation of the Act for an orthopedic surgeon to refuse to treat an HIV positive individual, unless it can be shown that the patient poses

a significant risk to the health or safety of others (including the physician), that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.

By excluding those who pose a direct threat, the Act and Final Rule recognize the need to balance the interests of people with disabilities against legitimate concerns for public safety. However, the determination that a person poses a direct threat to the health or safety of others may not be based on generalizations or stereotypes about the effect of a particular disability.

The determination of whether an individual poses a direct threat to the health or safety of others must be based on reasonable judgment that relies on current medical evidence or on the best available objective evidence concerning: The nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.<sup>24</sup>

An individual with a contagious disease may be considered disabled under the Act, depending upon the illness.<sup>25</sup> If the contagious illness is short-term, such as fever, influenza, or the common cold, it probably would not be considered “disabling” because it would not “substantially limit” a major life activity. On the other hand, a person with tuberculosis or hepatitis may be considered an individual with a disability under the Act.

(b) **Reasonable Modifications In Practice:** Discrimination also includes a failure to make reasonable modifications necessary to afford such goods,

<sup>17</sup> Report at 23, citing *School Board of Nassau County v. Arline*, 480 U.S. 273, 283 (1987).

<sup>18</sup> ADA, Section 302 (b)(2)(A).

<sup>19</sup> ADA, Section 302 (b)(1)(A).

<sup>20</sup> ADA, Section 302 (b)(1)(B).

<sup>21</sup> ADA, Section 302 (b)(1)(C).

<sup>22</sup> ADA, Section 302 (b)(1)(E).

<sup>23</sup> ADA, Section 302 (b)(3).

<sup>24</sup> The test was established by the Supreme Court in *Arline*, *supra*.



services, facilities, privileges, advantages and accommodations, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of the benefits.

Is a physician discriminating against a person with disabilities if the physician refuses to modify his or her practice to accommodate the disabled individual? Not necessarily. It depends upon the reason the physician refuses to treat the patient. For example, a physician who specializes in treating burn victims could not refuse to treat the burns of a blind person because of the victim's blindness. However, the physician need not treat the blind person if he or she does not have burns. Nor must a physician specializing in burn treatment provide other types of medical treatment to individuals with disabilities, unless the physician provides other types of medical treatment to non-disabled individuals. Thus, the physician's refusal to treat a blind person's hypertension may not violate the Act.

The physician may still provide medical treatment which in the physician's judgment is most appropriate, and may refer an individual with a disability to another physician when the physician would make such a referral of an individual who does not have a disability.<sup>25</sup> The Final Rule clarifies the point that physicians may refer an individual with a disability to another physician, if the disability itself creates specialized complications for the patient's health that the physician lacks the experience or knowledge to address.<sup>27</sup>

A drug rehabilitation clinic may refuse to treat a person who is not a drug addict, but may not refuse to treat a person who is a drug addict simply

because the patient tests positive for HIV.<sup>28</sup>

Public accommodations, which include hospitals and professional offices, which do not allow dogs must modify that rule for a blind person with a seeing-eye dog, a deaf person with a hearing-ear dog, or a person with some other disability who uses a service dog.<sup>29</sup>

Public accommodations may prohibit or impose restrictions on smoking.<sup>30</sup>

#### **(c) Integration of Individuals With Disabilities:**

Discrimination also includes a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the goods, services, facilities, advantages, and accommodations being offered or would result in an undue burden.<sup>31</sup>

#### **(d) Auxiliary Aids and Services:**

Auxiliary aids and services include: (1) qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments; (2) qualified readers, taped texts, or other effective methods of making visually delivered materials available to individuals with visual impairments; (3) acquisition or modification of equipment or devices; and (4) other similar services and actions with visual impairments;

A hospital or health care provider would not be required to provide these aids or services if it would result in

"undue burden," which is defined as an action requiring significant difficulty or expense. Factors to be considered in determining whether providing an auxiliary aid or service would result in undue burden, include: (1) the nature and cost of the auxiliary aid or service needed; (2) the overall size of the business of the covered entity with respect to number of employees, number and type of facilities and size of budget; and (3) the type of operation maintained by the covered entity, including the composition and structure of the entity's work force.

The determination of whether the provision of an auxiliary aid or service imposes an undue burden on a hospital or health care provider will be made on a case-by-case basis. However, a determination that a particular auxiliary aid or service would result in an undue burden does not relieve the hospital or health care provider from the duty to furnish an alternative auxiliary aid, if available, that would not result in such a burden.<sup>32</sup>

The question of whether physicians treating deaf patients are now required to hire sign language interpreters, to be in compliance with the Act, has been hotly debated. No judicial interpretation exists. The Final Report states that communications involving health, legal matters and finances are sufficiently lengthy or complex to require an interpreter for effective communication.<sup>33</sup>

However, the Act itself is not so clear on this point. Whether any given situation requires the use of an interpreter depends upon a number of factors, including: whether an interpreter is necessary to ensure effective communication with the patient; the

<sup>25</sup> Final Rule, § 36.208, citing School Board of Nassau County v. Arline, 480 U.S. 273 (1987).

See also ADA, Section 302(b)(3).

<sup>26</sup> Report 101-116 at 63.

<sup>27</sup> Final Rule, § 36.302(b).

<sup>28</sup> Id.

<sup>29</sup> Id.

<sup>30</sup> ADA, Section 501(b); Final Rule, Section 36.210.

<sup>31</sup> ADA, Section 302(b)(2)(A)(iii).

nature and size of the physician's practice or the treatment setting; and, the cost and difficulty of providing the aid or service, taking into account the factors listed above. If the individual with a disability is being seen by a physician in a small practice with a modest budget, and the patient is the only hearing impaired patient, then hiring an interpreter at \$100 per hour, to be present during a routine physical examination of that patient, the fee for which is less than \$100, may be regarded as an undue burden. However, if the topic of discussion is major surgery or a terminal illness, the situation may require the presence of a qualified sign language interpreter to ensure effective communication.

The Final Rule clarifies the definition of "qualified interpreter," as one who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary. A person who simply knows a few signs or how to fingerspell probably would not be considered a qualified interpreter. A family member or friend who accompanies the individual to the hospital or office may be asked to interpret. However, under certain circumstances those people, even if certified interpreters, may not be qualified to render the necessary interpretation because of factors such as emotional or personal involvement, or considerations of confidentiality that may adversely affect the ability to interpret effectively, accurately, and impartially.

The legislation is not intended to require individual doctors' offices to have telecommunications devices for the deaf ("TDD's"), since people with hearing impairments will be able to make in-coming inquiries and appoint-

ments with the doctor's office through a relay system established under Title IV of the ADA, and outgoing calls would be made by patients on an incidental convenience basis only. On the other hand, hospitals that offer nondisabled individuals the opportunity to make outgoing telephone calls on more than an incidental convenience basis must provide a TDD on request.<sup>34</sup>

The fact that providing one auxiliary aid or service would be unduly burdensome does not entirely relieve the individual physician of a duty to provide alternative means which do not constitute an undue burden. For example, under some circumstances, providing written materials to the hearing impaired containing the same information offered to other patients, may be utilized at little cost to the provider.

If the patient is being seen in a large metropolitan hospital, that hospital is more likely to be required to provide qualified interpreters or special equipment (telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for the deaf, closed captions, and decoders) for patients with impaired hearing. The Final Rule requires hospitals to provide, upon request, a means for decoding closed captions for use by an individual with impaired hearing.<sup>35</sup>

The same principles would apply to the provision of auxiliary aids and services for the blind, including qualified readers, taped texts, audio recordings, and materials in braille or large print. A physician in a small practice probably would not be required to provide braille materials to the patient, if the physician has someone read the written materials related to the treatment to the patient.

Neither physicians nor hospitals are required by the Act to provide individually prescribed devices, such as prescription eyeglasses or hearing aids.<sup>36</sup>

Neither the hospital nor the individual doctor's office is required to make available the most costly or elaborate method of communication, so long as the method chosen accomplishes the intent of the Act. The entity should consult with the patient before providing a particular auxiliary aid or service. Frequently, an individual with a disability requires a simple adjustment or aid rather than an expensive or elaborate modification envisioned by the covered entity.<sup>37</sup>

The cost of compliance with this portion of the Act may not be financed by surcharges limited to particular individuals with disabilities or any group of individuals with disabilities.<sup>38</sup> Thus, the cost of hiring interpreters cannot be passed along to the individual hearing impaired patient or spread among all hearing impaired or disabled individuals, at the exclusion of nondisabled patients.

**(e) Communication and Architectural Barriers:** Discrimination includes a failure to remove both communication barriers and architectural barriers that are structural in nature, in existing facilities.<sup>39</sup> To remove such barriers, public accommodations are required to make structural changes or to adopt alternative methods that are "readily achievable." By readily achievable, the Act envisions a change which would be easily accomplishable and able to be carried out without much difficulty or expense. In determining whether a modification is readily achievable,

<sup>32</sup> Report IOI-116, at 63.

<sup>33</sup> Vol. 56 Federal Register No. 144, at 35567.

<sup>34</sup> Report IOI-116, at p. 64; Vol. 56 Federal Register No. 144 at 35566-67.

<sup>35</sup> Final Rule § 36.303(e).

<sup>36</sup> Final Rule § 36.303(g).

<sup>37</sup> Report IOI-116, at p. 63.

<sup>38</sup> Final Rule § 36.301(c).

<sup>39</sup> ADA, Section 302(b)(2)(A)(iv).



factors to consider include: (1) the overall size of the covered entity with respect to number of employees, number and type of facilities, and the size of the budget; (2) the type of operation of the covered entity, including the composition and structure of the entity; and (3) the nature and cost of the action needed.<sup>41</sup>

If a change is not readily achievable, it is not required, even if it does not impose an undue burden.<sup>42</sup>

The types of barrier-removal envisioned for structures include the addition of grab bars, the simple ramping of a few steps, the lowering of telephones, the addition of raised letters and braille markings on elevator control buttons, the addition of flashing alarm lights, and similar modest adjustments.<sup>43</sup> The section may also require rearrangement of moveable furniture, equipment and display racks, but would not require the construction of elevators or extensive ramping of a flight of steps.<sup>44</sup> The readily achievable standard only requires physical access that can be achieved without extensive restructuring or burdensome expense.<sup>45</sup>

**(f) Alternative Methods of Barrier Removal:** Nonetheless, even if an entity can demonstrate that removal of a barrier is not readily achievable, discrimination includes a failure to make the benefits available through alternative methods if those methods are readily achievable.<sup>46</sup>

**Fixed Route Systems and Demand Responsive Systems:** Private entities operating a fixed route or demand responsive system (bus and/or van

service, for example), as defined in the Act, are required to ensure a level of service to individuals with disabilities, including individuals who use wheelchairs, equivalent to the level of service provided to individuals without disabilities.<sup>47</sup>

**New Construction and Alterations in Public Accommodations:** The provisions concerning new construction and alterations are more stringent than those concerning existing facilities. Discrimination includes a failure to design and construct facilities for first occupancy later than January 26, 1993 that are "readily accessible" to and usable by individuals with disabilities, unless the entity can demonstrate that it is structurally impracticable to do so.<sup>48</sup> Alterations that affect all or part of an existing facility must, to the maximum extent feasible, make the altered portions of the facility readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.<sup>49</sup>

The intent is to enable people with disabilities, including mobility, sensory, and cognitive impairments, to reach, enter, and use a facility. While the term "readily accessible" does not necessarily require accessibility to every part of every area of a facility, the term contemplates a high degree of convenient accessibility to parking areas, routes leading to and from the facility, entrances, usable bathrooms and water fountains, common use areas, and access to the benefits offered.<sup>50</sup> A reasonable number of parking spaces, bathrooms, and drinking fountains must be made readily accessible.

In a physician's office, "readily

accessible to and usable by" would include ready access to the waiting areas, a bathroom, and a percentage of the examining rooms.<sup>51</sup>

**The Elevator Requirement:** Under the Act elevators are required in all newly constructed buildings of three or more stories having at least 3,000 square feet per floor. However, newly constructed buildings housing offices of health care providers must have elevators, regardless of square footage or number of stories.<sup>52</sup>

The rules are different with existing buildings. What if a psychiatrist moves into a second floor office previously occupied by an accountant? There is no elevator. The general rule is that a professional office of a health care provider is required to remove architectural barriers to its facility to the extent that barrier removal is readily achievable, but is not otherwise required to undertake new construction or alterations. The Final Rule does not require the addition of an elevator to an existing two story building housing a professional office of a health care provider.<sup>53</sup> However, if alterations to the area housing the office are undertaken for other purposes, the installation of an elevator might be required, but only if the cost of the elevator is not disproportionate to the cost of the overall alteration.<sup>54</sup> Neither the Act nor the Final Rule prohibit a health care provider from locating his or her professional office in an existing facility that does not have an elevator

**Examinations and Courses:** Any private entity that offers examinations or courses related to applications,

<sup>40</sup> ADA, Section 301(9).

<sup>41</sup> Id.

<sup>42</sup> Report 101-116, at 65.

<sup>43</sup> Report 101-116, at 66.

<sup>44</sup> Id.

<sup>45</sup> Id.

<sup>46</sup> ADA, Section 302(b)(2)(A)(v).

<sup>47</sup> ADA, Section 302(b)(2)(B) and (C).

<sup>48</sup> ADA, Section 303(a)(1).

<sup>49</sup> ADA, Section 303(a)(2).

<sup>50</sup> Report 101-116, at 69.

<sup>51</sup> Report 101-116, at 70.

<sup>52</sup> ADA, Section 303(b).

licensing, certification, or credentialing for secondary or postsecondary education, professional, or trade purposes must offer the examinations or courses in a place and in a manner accessible to persons with disabilities or offer alternative accessible arrangements for those individuals.<sup>56</sup> SAT tests fall under this provision. The foregoing provision of the Act fills the gap created when licensing, certification, and other testing authorities are not covered by section 504 of the Rehabilitation Act (private entities receiving Federal money) or Title II of the ADA (operated by a State or local government). Private authorities must make all programs accessible to people with disabilities, which includes physical access and modifications in the way the test is administered. Modifications may include: extended time for completion of the examination; reading the examination to the hearing impaired individual or individual with learning disabilities; use of auxiliary aids and services such as taped examinations, interpreters, brailled and large print examinations, qualified readers and transcribers to write answers, or other effective methods of making aurally delivered materials available to hearing impaired individuals; and using written instructions.

A private entity offering an examination must assure that the examination is selected and administered in a way that measures the individual's aptitude or achievement level or other factor the examination purports to measure, rather than reflecting the individual's impaired sensory, manual, or speaking skills.

May an entity offering examinations for licensing or certification refuse to provide modifications or aids, on the basis rather than the disabled individual

would be unable to perform the essential functions of the profession for which the examination is given? No.<sup>57</sup> The examination must be modified to ensure that the place and manner in which the examination is given is accessible, regardless of whether the individual will be able to complete other requirements for licensure or certification. An action may be brought by either a disabled individual or by the Attorney General.

**Actions by Individuals:** A private individual who is being subjected to discrimination or who has reasonable grounds for believing that he or she is about to be discriminated against, may sue for money damages or to obtain an order to stop the discrimination, including temporary or permanent injunction, restraining and other orders. The person is not required to engage in a "futile gesture" if the person has actual notice that a person or organization covered by Title III does not intend to comply with its provisions.<sup>58</sup> If successful, the person may be awarded attorneys' fees and costs. The entity may be required to modify the facility or make available auxiliary aids or services, to alleviate any discriminatory effect.

**Enforcement By The Attorney General:** The Attorney General may investigate alleged violations of this title, and may file a lawsuit if the Attorney General has reasonable cause to believe that (1) any person or group of persons is engaged in a pattern or practice of discrimination under this title; or (2) any person or group of persons has been discriminated against under this title and such discrimination raises an issue of general public importance. The Attorney General may also conduct random compliance reviews.

In a lawsuit brought by the Attorney General, the court may order temporary injunctions, permanent injunctions, restraining orders, money awards and/or civil penalties.

The civil penalty to vindicate the public interest, for a first violation may not exceed \$50,000, and may not exceed \$100,000 for any subsequent violation.<sup>59</sup> Multiple violations adjudicated together are counted as a single violation, for purposes of determining the first and subsequent violations.<sup>60</sup> Punitive damages may not be awarded.<sup>57</sup>

**Mitigating Circumstances:** When the court considers the amount of civil penalty to award, it must consider any good faith efforts or attempts the entity made to comply with the Act, and whether the entity could have reasonably anticipated the need for an appropriate type of auxiliary aid.<sup>62</sup>

#### Effective Date

Title III became effective on January 26, 1992.<sup>63</sup> However, a lawsuit cannot be filed against a public accommodation employing 25 or fewer employees and having gross receipts of \$1,000,000 or less, for any discriminatory act occurring before July 26, 1992.<sup>64</sup> Suits against public accommodations employing 10 or fewer employees and having gross receipts of \$500,000 or less, may not be brought for any discriminatory conduct which occurs on or before January 26, 1993.<sup>65</sup> However, lawsuits concerning new construction and alterations in public accommodations and commercial facilities may be brought at any time.<sup>66</sup>

<sup>53</sup> Vol. 56 Federal Register No. 144, at 35584.

<sup>54</sup> Id.

<sup>55</sup> Id.

<sup>56</sup> ADA, Section 309; Final Rule, § 36.309(a).

<sup>57</sup> Vol. 56 Federal Register No. 144, p. 35573.

<sup>58</sup> ADA, Section 308(a)(1).

<sup>59</sup> ADA, Section 308(b)(2).



## Practical Considerations

The ADA establishes concrete standards of conduct designed to eliminate discrimination. Congress, through its Committees, the Equal Employment Opportunity Commission, the Department of Justice and others have issued their own interpretations of various provisions of the Act. However, ultimately the courts will decide on a case-by-case basis whether certain conduct discriminates against an individual with disabilities. The cases will refine and apply such terms as undue burden, readily accessible, reasonable modification, readily achievable, and direct threat. At this point, attorneys, health care providers and hospitals can only speculate about the outcome of any particular set of facts. The following examples are offered for demonstrative purposes only, and are in no way authoritative:

**Example #1:** A deaf person is referred to a vascular surgeon for evaluation and treatment of thrombophlebitis. When the patient arrives for his appointment he finds that the physician does not have a sign language interpreter available to facilitate communication. The patient lets it be known that he intends to sue if the physician refuses to hire a signer for the appointment and for any future professional contacts.

Is the physician required to hire a qualified interpreter? Does hiring a signer for this patient constitute an undue burden? The answer lies, in part, in whether providing a signer would be significantly difficult or expensive for the physician. The physician should be aware of the availability and cost of providing a qualified interpreter, and the availability and cost of other forms of auxiliary aids. The physician should also consider whether the professional

services can be properly provided through alternate means (such as handwritten notes), and whether the information can be effectively communicated without the use of a qualified interpreter. If in doubt, provide a qualified interpreter.

If possible, explain to the patient why an interpreter is not present. The physician may have a pre-printed explanation to hand to patients, although any such form first should be checked by an attorney familiar with the rights of the disabled. Ask the patient what method of communication he or she would prefer, and attempt to comply with the patient's wishes. Offer to communicate in writing or, if an option, talk so that the patient may read lips. Provide all significant information in written form, particularly information necessary to obtain an informed consent for treatment or surgery. While making oneself available to treat the patient, offer to refer the patient, at the patient's sole option, to another similar specialist who does have a qualified interpreter or other auxiliary aids available. What if the physician thinks he or she is offering a reasonable alternative to a qualified interpreter, and honestly believes that hiring a signer would be unduly burdensome under the circumstances, but is still sued? What are the chances of being hit with a big judgment or a \$50,000 "civil penalty?" It depends upon how reasonable the physician's conduct has been under all the circumstances, considering the size, nature and budget of the practice, considering the cost and difficulty of obtaining the service, and considering the ability to effectively communicate with the patient about the treatment without a qualified interpreter or other auxiliary aid.

**Example #2:** A general practitioner in rural Colorado practices alone from an office in a converted home. Must the physician modify the residence to provide access for the physician's one wheelchair bound patient? The answer depends upon whether modifications are "readily achievable;" that is, easily accomplishable and able to be carried out without much difficulty or expense. If there are a few steps that can be safely and inexpensively ramped with plywood, if new hinges on doors will make the waiting room, bathroom and an examining room accessible, and if bars can be installed in the bathroom with little difficulty or expense, those actions should be taken to comply with the ADA. The physician is not required to carry out extensive renovation of the property.

If modifications are not readily achievable, the physician nonetheless has a duty to make his or her services available through some other readily achievable method. For example, a readily achievable alternative may be performing the examination or providing the treatment at a location other than the physician's office (a house call, for example).

## Conclusion

The specific application of ADA provisions to the offices and practices of health care providers will be largely determined through judicial interpretation of the Act. Clearly, however, the Act was intended, in part, to eliminate discrimination in the delivery of health care to individuals with disabilities. Toward that end, the Act provides comprehensive rules aimed at making both health care and health care facilities accessible to the disabled. Its provisions cannot be ignored.

<sup>60</sup> ADA, Section 308(b)(3).

<sup>61</sup> ADA, Section 308(b)(4).

<sup>62</sup> ADA, Section 308(b)(5).

<sup>63</sup> ADA, Section 310(a).

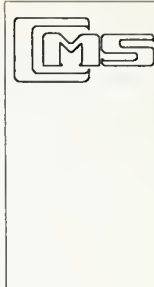
<sup>64</sup> ADA, Section 310 (b)(i).

<sup>65</sup> ADA, Section 310(b)(2).

<sup>66</sup> ADA, Section 310(b).







# EMS Physician Advisors: Duties and Responsibilities

*Emergency Medical Care Physician Advisors Committee (EMCPAC)  
Stewart Greisman, DO, Chairman*

The Emergency Medical Care Physician Advisors Committee (EMCPAC) of the Colorado Medical Society (CMS) meets every other month with representatives from the Board of Medical Examiners (BME), the Emergency Medical Services (EMS) Division of the Colorado Department of Health, the Colorado Trauma Institute and others to review the ongoing issues in the provision of emergency medical care in Colorado and the development of a statewide emergency medical care delivery system.

Many changes and advancements have occurred in the EMS system development area during the last year. In an effort to keep you apprised of these issues in general and specifically of the changes in responsibility for physician advisors, this is the first in a series of articles on the EMS system in Colorado.

## System Structure

The governance of emergency medical services in Colorado is fragmented. Individual counties throughout Colorado are responsible for the regulation, inspection and licensure of ambulance companies. The Colorado BME regulates physicians. Many of those physicians supervise the Emergency Medical Technicians (EMTs) working for the ambulance services. The EMS Division of the Colorado Department of Health regulates and certifies EMTs.

The EMS Division certifies EMTs and approves EMS training programs. The EMS Division develops the EMS training curriculum, which, by statute, must be approved by the BME. The Division does not, however, describe the scope of practice for EMTs, other than to say that EMTs can do that which they have been trained and certified to do. The duties and functions of emergency medical technicians, including the acts which they are authorized to perform, are regulated by the rules and regulations of the BME. The BME regulations are entitled *Rules defining duties and responsibilities of EMS physician advisors and the authorized medical acts of EMTs and paramedics* and are commonly known as the *Acts Allowed*. These rules describe what physician advisors may allow their EMTs to do and therefore, in essence, define the scope of the EMTs' practice.

And we wonder why it is so difficult to create a state wide EMS system in Colorado!

## The Acts Allowed

The *Acts Allowed* defines the duties and responsibilities of physician advisors to emergency medical care service agencies and the authorized medical acts of Emergency Medical Technicians (including all levels: Basic; Intermediate and Paramedic). They apply to any physician who functions as a physician

*Many changes and advancements have occurred in the EMS system development area during the last year.*

# Emergency Medical Services (EMS)

*And we wonder why it is so difficult to create a state wide EMS system in Colorado!*

advisor to an EMS organization and who authorizes and directs the performance of medical acts by EMTs at all levels of certification in the state of Colorado.

The *Acts Allowed* were revised in August of 1991. The most significant changes are:

- Requirement that EMT-Basics must have a physician advisor by June 29, 1992.
- Addition of Automated External Defibrillation as an allowed EMT medical act with the accompanying requirement that:
  - physicians supervising EMT-B defibrillation must develop a quality control program

The requirement for supervision of EMT-Basics created a good deal of controversy, especially given concerns regarding the difficulty in finding such supervision in many of the rural areas. It was felt, however, that the ability to improve the quality of emergency medical services depended on strong medical control and quality management. It should be noted that very few rural areas are currently without such advisors.

Following is a summary of the key changes in the *Acts Allowed* (information courtesy of the EMS Division):

1. The definition of a service agency has been changed to include a "rescue unit" which, as defined in statute, includes search and rescue, mountain rescue, ski patrol (both volunteer and professional), law enforcement posse and civil defense unit.
2. The physician advisor "must be trained in Advanced Cardiac Life Support according to the standards of the American Heart Association." (emphasis ours)
3. The Physician Advisor must report to

the EMS Division termination of EMTs (if the reasons for such termination could lead to disciplinary actions).

4. An EMT-Basic who is a member of a service agency and performs emergency medical service acts **must have the authorization of a physician advisor** to perform such acts. Previously, EMT-Basics did not have to have physician advisors.
5. Previously, EMT-Intermediates could administer authorized drugs only under direct verbal authorization of a physician. The rules, as amended, allow for a waiver, which would enable standing orders to be implemented for specific EMT-Intermediates. The waiver must be approved by the BME prior to implementation of the standing orders.
6. Colorado joins some 40 states that allow EMTs to perform automated defibrillation. This is a new section and includes the following requirements:
  - a. The physician advisor must be able to demonstrate the use of AED.
  - b. The EMT-B can only be authorized after successful completion of an AED training course.
  - c. The AED must have voice and EKG recording capabilities.
  - d. Only automatic or semi-automatic capabilities (not fully manual) may be used by EMT-Basics.
  - e. Sixty days prior to authorizing EMT-B's to perform AED, the physician advisor must submit to the EMS Division the following:
    - 1) AED registration form
    - 2) Medical Quality Control Program, which must be approved by the Board.
    - 3) The following records (submitted by the physician advisor or a



designee within 30 days of each use of the AED):

- a) a copy of the AED reporting form completed by the EMT-B performing the act and signed by the physician advisor.
- b) a copy of the pre-hospital care record (trip report).
- c) a copy of the electronic media recorded by the AED (including the voice).

The requirement for a medical quality control program is not new, but increased emphasis will be placed on it as a tool to aid the physician advisor.

## Support Available

It is just within the last few years that the BME and EMS Division have established an ongoing working relationship in an effort to coordinate EMS activities. As a result of their work, there is now a real effort to develop a state wide EMS system. As these two agencies and those involved in EMS throughout Colorado are trying to develop this system, many changes are occurring.

- The EMS Division now has a medical director to provide medical direction to the division and to be available as a resource to rural physicians.
- The *Acts Allowed* were revised in August of 1991.
- New emphasis is being put on the old requirement for quality control programs.
- Grant money is available through the EMS Division for use by local EMS providers in efforts to improve the state wide emergency medical network.

The BME and the EMS Division recognize that meeting the requirements of the rules will be difficult for some

EMS agencies. The intent of the EMS Division is to approach the enactment of these rules in phases and to **provide technical assistance** to EMS agencies in need. The EMS Division is identifying those ambulance services who do not have physician advisors and working with them to establish quality control programs and find physician advisors. Technical assistance is also available to fire departments and search and rescue agencies looking for physician advisors.

The BME and EMS Division have also developed a training course for physician advisors. The course objectives are:

- Development of a medical quality control program
- Acquiring better quality assurance methods than just reading ambulance trip reports
- Understanding and implementing "medical control" within the political realities of supervision in an EMS system

There have been five well attended presentations to date. An additional three are possible during this year. The program is a full day presentation and is free as it is funded through the EMS Grant Program. Travel reimbursement may be available. Physician advisors are encouraged to bring their EMS coordinators to the program, which eliminates the need for the physician to train the coordinator. Copic supports this program as well. Physician advisors are covered under their existing Copic policies.

In addition, the EMS Division now has a medical director. Dr. Kathryn Mueller is available as a resource to physicians.

*For further information, please contact:*

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Emergency Medical Services  
Division  
Colorado Department of Health  
(303) 331-8633*

*Kathryn Mueller, MD  
Medical Director, EMS Division  
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(303) 894-7705*

*Stewart Greisman, DO  
Chairman, EMCPAC  
(303) 779-5455 or 788-6407*

# Prescription Drug Abuse: It Could Happen to Somebody's Mother

Lugene A. Dorr, M.D.  
Prescription Drug Abuse Task Force

*How could this have occurred without a physician checking more closely?*

At a recent meeting of the Grievance Committee, a letter was presented from an officer of our Armed Forces in regards to his mother who lives in Colorado. He had visited her at Christmas time 1991 and found his 63 year old mother shuffling around, barely speaking and almost emotionless. In checking for a reason for her condition, he found over 20 empty prescription bottles in her medicine cabinet. He states that the number of empty prescription bottles found eventually reached 45.

On checking with the pharmacies listed, he deduced that his mother was taking an average of six Restoril, 30 mg. capsules, several Lomotil tablets and cough medicine daily. During the time of his visit, his mother did collapse and with the assistance of his sister and brothers, his mother was admitted to a chemical dependency unit in Denver, where she remained for the next 24 days.

It is estimated that the cost of her treatment, which continues even now, will exceed \$50,000. He admits that his mother manipulated the system to obtain drugs. She used several doctors and various pharmacies. She phoned in requests for refills and had them mailed to her home. She frequently "lost prescriptions" or reported that she had

dropped the pills down the drain. She intentionally scheduled doctor office visits for a time when she knew her primary doctor would be out of his office.

The officer asks several penetrating questions about how this could have occurred without some physician checking more deeply into what was occurring. He points out from his investigation that the patient was receiving Restoril on an average of 5 capsules per day. The doctors were approving phone prescriptions for 100 capsule bottles of Restoril approximately every 20 days. She was also receiving Lomotil and cough syrup, and he underlines that these drugs were being given to a 63 year old, 85 lb. woman with a driver's license and an automobile.

It appears that this is a system breakdown which could occur, particularly if a patient is seeing multiple physicians and using different pharmacies. This officer gave permission to use this case as an example and asks that we alert the members of our Society to the risks and warning signs of prescription drug abuse and manipulations that patients are likely to use in order to obtain the medications.

Enough said.





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# The Class of 1992 and the CMS in the Year 2000

*by Nancy Nelson, MD\**







You are invited to attend the Hooding and Oath Ceremony for the graduating medical school Class of 1992 on Saturday morning, May 23, 1992, at 10 am in the Quadrangle of the University of Colorado Health Sciences Center. Our new physicians will take the Physicians' Oath (a modern version of the Hippocratic Oath). U. S. Surgeon General Antonia Novello will be the graduation speaker. You will have the opportunity to meet the Class of potential Colorado Medical Society delegates in the year 2000.

CMS President Harrison G. "Corky" Butler, III, MD and Medical Alumni President John DeLauro, MD are in charge of the hooding with green, silver and gold hoods. Some of you as parents and mentors of graduates will serve as individual hooders. Call the Office of Student Affairs (270-7678) for more details.

Who are these 125 graduates? Some are your actual sons and daughters. They are all our children, as future physicians. Most of the graduates came from Front Range high schools, while a few (about 3%) came from rural Colorado high schools. About two thirds graduated from Colorado

colleges and universities, while others came to medical school from schools throughout the United States and throughout the world. Some of the graduates are immigrants who fled political oppression to come to this country. Several have had professional careers prior to medical school — in nursing, chiropractic, pharmacy, athletics, banking, engineering and education. One senior was a police detective, another a commercial airline pilot and another is

a professional mime. Several are professional musicians in both classical and rock music. One graduate is both a nurse practitioner and the mother of an Olympic speed skier.

Almost half (44%) of the graduating class are women. This percentage has remained steady for about the last decade, as you will note in the class composite pictures hanging in the entrance to the School of Medicine. Our medical school was a national leader back in the 1970's and 1980's in encouraging women applicants. This year there are seven Hispanic American graduates and three African American graduates. Though there are no Native American graduates this year, there are several Native Americans in medical school now. Eight of the graduates are in Army and Air Force programs.

Over 90% of the class received their first or second choice of residency slots in the Match this spring. Forty-five percent of the class will stay in Colorado for residency. It is estimated that half the others will eventually return to Colorado to practice.

Over 50% of the class will enter the generalist physician fields of Family Medicine (18), Internal Medicine (28) and Pediatrics (13) and one graduate will do a joint residency in Internal Medicine and Pediatrics. The current national average of those entering generalist fields is 38%. It is unknown how many of those doing Internal Medicine, Pediatrics or Family Medicine residencies will subspecialize.

The continuing high quality of entering students at the University of Colorado School of Medicine is a major reason for the quality of our graduates and contributes to their ease in finding superior residency training programs. During the 1980's there was a national drop in the number of medical school applicants. Colorado's pool stayed strong during that national lean period. Now the national applicant pool has expanded again in inverse ratio to interest rates and other economic and social factors. Colorado has 1,700 applicants for its 130 seats in the first year class which will matriculate in late August, 1992. Dr. Gus Garcia, Dr. Mel Johnson, Dr. George Curfman, Dr. Jack Mueller and Dr. Donn Thomas are members of the Admissions Committee who can give you more information



# Class of 1992 and CMS 2000

## *Who ARE These New Physicians?*

- *Over half are "Generalists"*
- *Nearly half are women*
- *Many minorities are represented*

about the process. (Stephen Batuello, MSIV, one of our soon-to-be graduates sits on the Admissions Committee in addition to his duties as the first student member of the CMS Board of Directors).

The Committee accepts a few non-Colorado students (at a tuition of \$39,000/year, the highest out-of-state tuition of any public medical school). The Admissions Committee could easily fill the class with out-of-state students, but then it wouldn't represent Colorado, would it? Since the applicants are quite bright, many have figured out that if they sit out a year while establishing residency in Colorado before making application, they can save lots of money. In-state tuition is about \$9,000/year, also high from a national standpoint. Our graduating students who have taken out loans will have a total indebtedness of over \$50,000 when they receive their diplomas.

Based on the demographics of the graduating Class of 1992, the Colorado Medical Society in the year 2000 will include more women physicians and a growing number of African-American, Asian-American and Hispanic American physicians. Because there are still few Native American medical students, there will only be a couple of Native American CMS members in the year 2000, though this will be an increase of our current count of zero. (Has there ever been a Native American physician in the Colorado Medical Society?)

More of the CMS members in the year 2000 will be generalists. This will follow Colorado and national trends pointing toward the blossoming of the generalist physician. (Generalist is the new term for what has been called the primary care physician. Generalist is a concept more easily understood than primary care.) "Generalist" is now

applied to Family Medicine, General Pediatrics and General Internal Medicine. This term is sometimes applied to physicians practicing Emergency Medicine, Psychiatry and Obstetrics/Gynecology. Some physicians in subspecialties practice as generalists on occasion.

Our medical students understand the need for a larger percentage of generalist physicians, both for the benefit of society and for the profession of medicine. Physician payment plans are headed in the direction of the generalist. Support from many areas for generalist physicians promises to increase. Subspecialists will always be needed but as a smaller percentage of the physician population.

Medical scientists, such as the MD/PhD are also in short supply and will need to be nurtured for the continued advancement of the field of medicine. There is one MD/PhD graduate in our class of 1992 and more are in following classes.

Many of the class of 1992 who do residencies in Colorado will want to join the CMS as resident physicians. Others who do residencies out-of-state will be invited to join medical societies from which they can transfer back to Colorado. Our medical future, the Class of 1992, is strong in accomplishment and promise. Come to the Hooding and Oath ceremony to welcome them.

\* Dr. Nelson is Associate Dean for Student Affairs at the University of Colorado School of Medicine, Past President of the Denver Medical Society, Past Member of the Board of Directors of the Colorado Medical Society and, with Dean Richard Krugman, Dr. Stuart Gottesfeld and Dr. Eugene Jacobson, serves as a delegate to the Medical School Section of the American Medical Association.



# Sunscreen Q & A

The Colorado Division of the American Cancer Society maintains Task Forces to cover four major cancers predominant in the Rocky Mountain Area. One of those four is skin cancer. Barbara Reed, MD chairs that task force and has prepared an article answering some of the most commonly asked questions they encounter.

Ronald E. Tegtmeier, MD  
Chair, Professional Educational Committee, Jefferson County Unit  
American Cancer Society

## 1. Do sunscreens cause cancer?

There are some reports which are under study at the present time that PABA containing sunscreens may contain undetermined amounts of nitrosamines as a breakdown product/contaminant. There is no testing which has been done to determine whether or not the nitrosamine is a carcinogenic agent. Further, it is unclear how the contaminant or breakdown product is formed and whether it is even present at all in most PABA containing formulations.

We know that sunburn has a role in the production of skin cancer. We know that ultraviolet B is primarily responsible for sunburn. We know that sunscreens protect against the production of sunburn. What is unclear is whether or not there are carcinogenic effects produced by ultraviolet B or low range ultraviolet A which may not be prevented by the prevention of sunburn alone.

Excessive exposure to sun is therefore, discouraged.

## 2. Is there a role for sunscreens in the day to day activities of indoor workers?

Certainly the risk of sunburn is minimal in indoor workers. If sunscreen is being used only for the prevention of sunburn, it has minimal use during the winter months in an indoor worker, however, indoor workers often find excuses to be out of doors, when ultraviolet may produce harmful

effects. For example, a ten minute walk through the park in the presence of fresh fallen snow may be sufficient to induce mild erythema in an extremely sensitive individual.

A second argument for daily use is that using sunscreen will easily become a habit. This minimizes the possibility of forgetting.

Finally, some sunscreens may prevent the development of lentigines, mid dermal elastolysis, coarsening of the skin and other signs of sun exposure.

## 3. What is a "broad spectrum" sunscreen and when should one be used?

A broad spectrum sunscreen is one which protects against ultraviolet A, 320-400 nanometers, and ultraviolet B, 290-320 nanometers. Most of the carcinogenic effects of ultraviolet are felt to be due to ultraviolet B, although it is likely that the lower wavelengths of UVA now known as UVA I may also contribute to the development of skin cancer. UVA also contributes to signs of aging, including guttate hypomelanosis, lentigines, senile purpura, rhytides and loss of elasticity.

Ultraviolet A is present as long as there is daylight. It passes through window glass. Ultraviolet B, on the other hand, exerts most of its effect in the midday hours.

Many rashes which are due to drugs are also felt to be promoted by ultraviolet A as well. Therefore, a broad

Barbara R. Reed, MD

# Sunscreens

spectrum sunscreen is advisable for anyone on photosensitizing medications, anyone with photosensitivity due to genetic or acquired disease states, and anyone concerned about minimizing the adverse effects of ultraviolet.

## **4. *Is the sunscreen in makeup sufficient to protect skin on a daily basis?***

Cosmetic products labeled as containing sunscreen contain an SPF of six or less. The sunscreen is unlikely to be broad spectrum. For patients who are photo sensitive, on photo-sensitizing medications or concerned about aging, a sunscreen with an SPF 15 (at least) is advised.

## **5. *Are there indications for use of a sunscreen with an SPF over 15?***

The Food and Drug Administration is revising its guidelines on sunscreens and is expected to issue them within the next several months. There is definitely a role for sunscreens with high SPFs. SPF is determined using an amount of sunscreen which is much more generous than the average person uses. Many sunscreens have very little substantivity; that is, they wash off in water or rub off. In other words, a person who applies very little sunscreen is not likely to have applied the SPF indicated by the label.

Further, there is evidence that sunscreens with high SPFs protect against microscopic damage to cells in a manner in which sunscreens with low SPFs do not.

In no way, however, should use of a high SPF sunscreen promote lengthy sun exposure, which would permit excess UVA exposure. UVA is felt to augment tumorigenic potential of UVB, thus increasing the risk of basal cell cancers, squamous cell cancers and melanoma.

## **6. *How worried should we be about the ozone layer deficit?***

This is a definite problem. A one percent decrease in the ozone layer translates into an increase in UVB which is approximately two percent, and an estimated three to four percent increase in the incidence of skin cancers. This summer, with a three to four percent deficit in the ozone layer projected in Colorado, it is possible that a person extremely sensitive to the sun may burn in as short a time as ten minutes.

## **7. *Are there any special tips for sunscreen use on the scalp or around the eyes?***

Many patients complain of eye burning and irritation with the use of sunscreens. There are several solutions to this problem:

First of all, a sunscreen formulated for children's use may be very helpful.

Secondly, sunscreen may be prevented from dripping into the eyes by the use of waxy lip balm with a sun protective factor. The lip balm is applied just beneath the brow and may be extended across the bridge of the nose.

Patients with thinning hair often object to the use of a cream sunscreen because of its effect on the hair. For such people, an alcoholic spray sunscreen is available. Patients should be cautioned that such sunscreens are alcohol based and have less substantivity than the greasier formulations, thus requiring reapplication frequently. An opaque hat is often preferable.

It is extremely important to remind patients to protect their ears and lips as well. A recent study showed an extremely high risk of metastases from cancers beginning on the ears and lips.

## **8. *What about the use of sunscreen for children under six months of age?***

There is no reason for children less than six months of age to be intentionally exposed to the sun. It is well known that a single severe sunburn in a child under the age of 18 doubles the risk of skin cancer, including melanoma. Children should be kept out of the sun and well protected by clothing.

For children over six months of age, the same guidelines apply. Sunscreens certainly may be applied to children; however, sun avoidance during the mid portion of the day is preferable.

## **9. *How protective is clothing?***

The estimated SPF of light, summer-type clothing varies between 4 and 12.

Loosely woven, gauzy clothing has a very low sun protective factor. More tightly woven clothing may be fairly protective. There are some commercially available wearing apparel items which have a sun protective factor of 36 and these are quite well accepted by patients.

Clothing intended for use as sun protection may be examined by holding it to a light bulb. If the light bulb can be seen through the clothing, its sun protective factor is inadequate. Sunscreens must then be worn beneath the item.

## **10. *What is the best sunscreen?***

The best sunscreen is the one which patients will wear on a regular basis. It should have a high sun protective factor and should not cause irritation.

Because testing of sunscreen ingredients is standardized, determination of the best sunscreen must be made on an individual basis.



**Q: What is the most commonly used medical procedure?**

**A: Communication!**

**Did you know that on average, the physician interrupts the patient eighteen seconds into the...**

**What?**

In a 1986 survey, patients indicated that 35% of the malpractice suits they filed were directly related to the physician's poor communication, and another 35% to the physician's attitude (at least, as they perceived it). Good communication is good patient care!

Find out more in the **Miles Physician-Patient Communication Workshop**, coming soon.

May 20

June 17

July 9

**Saturday, August 1**

August 19

September 23

**Saturday, October 3**

October 20

November 12

December 9

*Now on Saturday!*

Workshops held from 8:00 am to 12:30 pm at CMS/Copic Headquarters, 7800 E. Dorado Place, Greenwood Plaza, immediately behind the Hilton Inn South, off I-25, Orchard Road Exit. Call Copic Risk Management for more information (303) 779-0044 or 1-800-421-1834.

*These workshops are presented by the COLORADO COMMUNICATIONS COALITION, including the Colorado Foundation for Medical Care, Colorado Medical Society, Colorado Personalized Education for Physicians, Colorado Physician Health Program, Colorado State Board of Medical Examiners and the Copic Insurance Company. They are taught by Kenneth A. Kahn, MD and Frederic W. Platt, MD for CMS, Kathy Gardner, BSN, Richard H. Thompson, Jr., MD and Margaret Cary, MD (BME) for Copic. Participants are eligible for 4 hours Category 1 CME credit and one Copic EN Point for Preferred Risk Premium Plan. Registration fee is \$100; Copic insured physicians receive a refund. Maximum enrollment is 25, minimum is 12. If that number is not reserved two days prior to the scheduled date, that workshop will be cancelled and fees will be refunded.*

## Special Meetings for Women in Medicine Health Care Policy for the 90's and Beyond

In connection with the state wide series of meetings on health care reform, the Women in Medicine Section of the Colorado Medical Society is offering a significant opportunity for female physicians to have input. Please attend one of the meetings:

### Denver

May 21 — 6 pm

CMS Board Room

RSVP Marilyn Barton, 779-5455

### Colorado Springs

June 4 — 7:30 am

El Paso County Medical Society

RSVP 591-2424 or 591-2481

### Grand Junction

July 9 — 6:30 pm

G. B. Gladstone's (dinner)

RSVP 243-2808

### Pueblo

June — To be arranged

# Medicare Fee Schedule:

*Have you read all the information?*

By the time you read this article, you'll have worked with the Medicare Fee Schedule for several weeks. Hopefully, you've read and are familiar with all the information that was sent to you by your Medicare carrier and by the AMA and have a working knowledge of the new system. I won't repeat the party line here and rehash the things you already know. I'll discuss a few of the major problems and share with you a few special pointers and hints on how to work with the program.

## **A Double Whammy**

Physicians and their offices were hit with a double whammy with changes in the Medicare Fee Schedule and CPT codes, both of which came late last year. These changes have created a major challenge for all of our offices. The combination of the two has mandated that we modify the way we do business. Adoption of the CPT codes by Medicare forces physicians to learn both systems quickly, and the Medicare Fee Schedule is the law of the land. If physicians are inconsistent with that law, they will either be paid less than deserved or they may even be found guilty of fraud. You probably wouldn't go to jail for not understanding the system, but it could cost you a lot in penalties and fines.

## **The Good**

There is some good in the new system, such as the upgrading of evaluation and management (E/M) codes, the new definitions of consults and new patients. In addition, the standardization of some of the rules, e.g., the new global fee for surgical procedures; will be good for physicians in some areas and bad for others.

## **The Bad and the Ugly**

When I think of discussing the bad and the ugly, it reminds me of the cartoon where the nurse is standing holding a smoking gun, and the caption states "so many doctors and so few bullets." The new system leaves one with the feeling "so many problems and so little space." Yes, the long awaited physicians' review has been implemented. No, it's not what we wanted, nor is it what we should have received. The final results don't reflect the original concept. What happened to fairness and equity in reimbursement?

## **Loss of Income**

The loss of income to physicians will be greater than anticipated. You might ask why I feel this way (I'm sure HCFA will). Let me give you some answers and examples as I see them.

### ***Lowering the Conversion Factor***

To begin with, the final conversion factor was lowered to achieve "Budget Neutrality." A portion of the adjustment was to compensate for behavioral offsets." I know this is old hat to many since most of us wrote letters of objection to HCFA, but it should still make you angry. Let me quote from page 59512 of the Federal Register, November 25, 1991:

For physicians predicted to experience a net loss of Medicare revenues, we assumed volume and intensity changes sufficient to offset 50% of the loss of Medicare revenues that would otherwise occur. We assumed no change in volume or intensity by physicians expected to experience a net increase in Medicare revenues.

This implies that physicians will try to game the system. There always have been and probably always will be some who do. However, this statement



# The Good, the Bad and the Ugly

M. Ray Painter, Jr., MD  
CMS Delegate to the AMA

refers to *all* physicians. HCFA didn't determine that perhaps 10% or 20% of the physicians would be guilty, but simply assumed that all physicians would be guilty and lowered the conversion factor accordingly. This is insulting to me personally and to the entire profession.

## **Other Less Publicized Changes**

Other, less publicized changes will also result in lowered income. For example, the non-payment of supplies, the change in global fees and the downcoding of evaluation and management (E/M) codes resulting from the use of the new coding system. These factors were not taken into consideration by HCFA or the AMA in preparing simulations to determine who and how big the winners and losers were. I feel very strongly that the total impact on the physician community will be much greater than those suggested by the projections we've seen. The American Association of Clinical Urologists is developing a simulation to compare actual Medicare reimbursements for a number of urologists in 1991 under the old rules to the simulated projected payments under the new 1992 rules. As stated, I think the loss will be much greater than predicted for most physicians. The gain for others will be less than anticipated.

## **Supplies**

First, let me point out that relative values were established using the content of work as their basis without consideration for supplies. HCFA then decided that a certain percentage of each payment was to pay for overhead. In the final rules, it was determined that all supplies furnished in the doctor's office were reimbursed as a part of the office visit.

To justify its actions, HCFA stated, "We computed these payments (for supplies) in a budget neutral manner by

factoring in when we computed the conversion factor." If they're paying me for supplies because of an increased conversion factor, why don't I feel good when I insert a Foley catheter for a payment of \$10, and then I have to pay for the catheter, the cath tray and other supplies?

## **Downcoding**

The third example is downcoding, resulting from the use of the new E/M codes. If you break down the E/M code components into their elements and compare the elements of the new codes to the elements of the old codes, it becomes apparent that you have to do more work to justify using the higher (upper four levels) codes in the new system than you did in the old. For example, a level five new patient visit in the old system may have to be classified as a level four in the new system. Only a few of the old classification class fives will justify a class five level in the new system.

The bottom line is that some of the increase we anticipated receiving on the E/M codes will be lost in the downcoding. The examples could go on and on.

## **Global Fees**

Under the old system, physicians in some states were able to charge for post-operative visits and some secondary procedures that are now included in the global fee.

## **How to Work with the New System**

I won't continue to bore you with examples that only serve to reinforce that sinking feeling you've already had. Let's talk about a few specifics on how to work with the new system. I'll only comment on a few of the more important changes that are necessary to work within the new system.

*"Physicians and their offices were hit with a double whammy"*

# Medicare: Good, Bad & Ugly

*"Document what you do.  
Charge what you document.  
If you didn't document it,  
You didn't do it."*

## ***Know How to Accurately Use the Rules and Make Coding Decisions***

The standardization and preciseness of the new rules and regulations and the specificity of the new E/M codes demand a working knowledge of the new system. You must know how to accurately use the rules and make coding decisions. The new E/M codes should be visualized as a time bomb sitting in your office ready to explode within the next seven years. Specificity allows you to accurately determine the proper code to describe the service rendered. At the same time, it allows someone to retrospectively review your charts and determine the proper coding for the service performed.

Specificity not only demands accuracy, but it also makes proper documentation a must. Our new motto should be:

*"Document what you do  
Charge what you document  
If you didn't document it  
You didn't do it."*

You should code for the work you do. If you under code, you will not be paid for services rendered. If you over code, you'll risk penalties and repayment.

## ***Determine the Proper Code and Document Everything.***

The proper code can be determined in two ways: 1. examine the descriptors given in CPT and determine the proper content of work performed; 2. refer to the clinical examples given in CPT and compare your encounter to them. In my opinion, your accuracy in coding will be judged by the documentation of the work you've performed. The clinical examples will be used as a comparison to determine whether your work was justified.

In keeping with that theory, I've developed a "cheat sheet" to help determine which code level to charge. I don't have the space to develop all the information to enable you to fully understand this. This "cheat sheet" however, and a complete description of the steps leading to its development will be included in the new Urology coding book update which will be available soon. The cheat sheet is copyrighted by Physician Reimbursement Systems, Inc. Feel free to use it as you wish. However, please don't copy and send it to your friends.

Specifically, we have taken the components in each level of service for a new patient code and an established patient code. The descriptors have been broken down, not only into components, but also into the elements of the components. We see those elements as the minimum amount of documentation needed to charge for that code. If this doesn't confuse you, probably nothing will. Play with it a little bit and, hopefully, it will make sense. I hope you find it useful.

## ***Consults***

Finally, as mentioned above, one of the better things that has happened in the change is the new descriptions of consults. Most of the categories of services in the CPT book are specific for location of service, (e.g. office, hospital, nursing home, etc.). Consider consults to be the wild card of the group! Under the new definition, (see CPT book) you may consider any encounter a consultant visit (if it meets the three criteria) regardless of: whether the patient is new or established; the problem is new or is a problem you have evaluated before; the location of the visit.



## Emergency Care

The new emergency codes can be used by any physician when seeing a patient in the ER. Therefore, when a patient is seen in the ER, you have a choice of three categories of codes to properly charge for that service:

1. Consult—see discussion above. If the evaluation is requested by another physician, this may be your best choice.

2. Office Visit Codes—The use of these codes penalizes you in two ways: First, you must use the established patient codes if you have performed a service for that patient during the past three years; and second, these codes are subject to the out-patient limits, resulting in a decrease in charge limits and a decrease in reim-

bursements.

3. Emergency Codes—These may be your best choice if the encounter does not qualify as a consult.

## Summary

We must learn to work with the system. Unfortunately, today's coding is such that you cannot leave this to your coding clerk, as many of us have done in the past. The specificity of the new system will demand that the physician be actively involved in coding of all E/M services. One must consider using all levels of codes. The person who learns to correctly work with the system and charge correctly for services rendered will be better paid and run less risk of denials and penalties.

So much to say and so little space to say it.

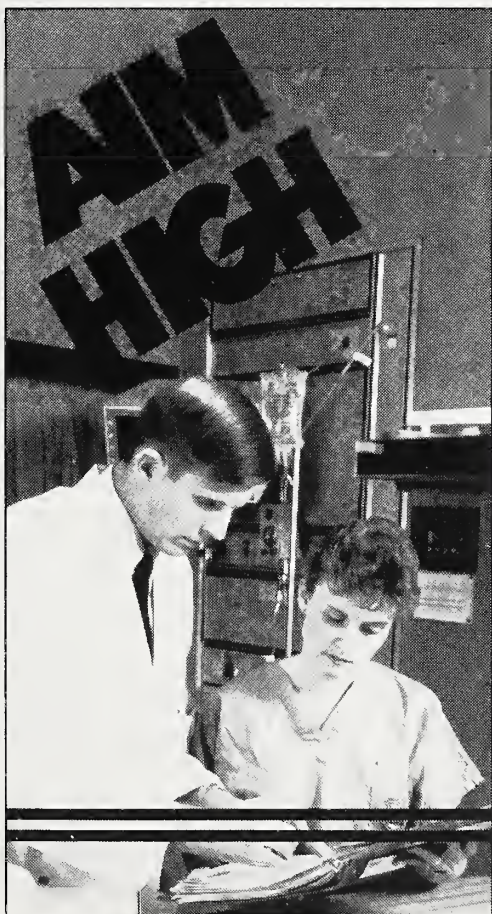
*"The specificity of the new system will demand that the physician be actively involved... today's coding is such that you cannot leave this to your coding clerk."*

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Edie Register, Director  
Health Care Financing Department

## Visit Codes and Dump Codes

Grant Steffen, MD  
Medical Director, Medicare Part B  
Blue Cross/Blue Shield of Colorado

*"This review is based on the presence or absence of fairly easily identified elements."*

I mentioned in a recent article about the new Evaluation and Management Codes (visit codes) that we will conduct an Early Claims Review during the first half of 1992. We have some figures from the first two months — January and February. Recall again that this review identifies 25 claims each week, asks the physician to send a copy of the record on which the claim is based, involves our reviewing the claim and finally a determination that the level of the visit code was too high, just right or too low. Again, this review is strictly educational. No penalties will be issued.

For January and February, we asked for 64 records (that's all the E/M claims we got), got back 58 and determined that 19 of the 58 (33%) were coded correctly, 36 of 58 (62%) were coded too high, and 3 of 58 (5%) were coded too low. The incorrect level was almost always a matter of one level but on two occasions I judged the correct code to be two levels below the level billed.

One was a hospital chart note and the claim was for 99233, the highest level of a subsequent hospital visit. This requires a detailed history, i.e., present illness, extended review and pertinent past, family or social history. The note had a total of seven words, two of which could be considered "history."

Code 99233 requires a detailed exam, an extended examination of the affected body area(s) and other symptomatic or related systems. Three of the seven words described an exam. The remaining two words constituted a recommendation. I hope you will agree with me that the documentation warrants only a 99231.

Unlike many types of review where differences of opinion are justified, this review is based on the presence or absence of fairly easily identified elements. If there is no past, family or social history recorded, it is not a detailed history. I believe that the majority of the overvalued codes reflect, not an attempt to game the system, but rather a lack of understanding of the new visit codes.

There were a few records that suggested that a good deal of counseling occurred, but this was not recorded nor was any time recorded. If you find that counseling took more than half the "time," so indicate with a note that describes the content of the counseling, the time the counseling took and the total time. This may well justify a code higher than that justified by the degree of intensity of the history, exam and decision making.

I will report back to you on how this review goes for the next four months. And for a change of subject, I



need to mention the "dump codes," those codes that end with 99 and are described as "unlisted procedure, ...system." Because this code encompasses many different procedures, the system can't pay one amount, so all ...99 codes must be priced by RN's, who bring many of them to me. We call them dump codes because the physician or the billing clerk can't find a code that describes what is done, so the procedure is "dumped" into the ...99.

On many of the claims that I have reviewed, I was able to find a non-dump code that described the procedure. So please make a vigorous attempt to find a code — it's probably there. Also, be aware that we must have the operative note before we can process a claim containing an unlisted procedure code.

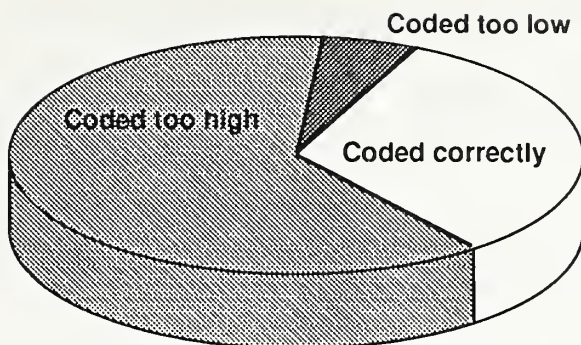
When I get this claim with op note, I first look for the "true code." If I can find it, we pay on that code. If not, I try to find a procedure that has the same amount of work. If I find a good match, we pay on this code. If I can't find that match, I refer the claim to a consultant of similar specialty. This all takes time and delays your payment. So please try to find a non-dump code and, failing that attempt, send us your op note.

### National Practitioner Data Bank (NPDB)

Does the Colorado Foundation for Medical Care (CFMC) report severity level I, II, or III quality problems to the NPDB? That was the question asked at the last Colorado Medical Society (CMS) Board of Directors meeting.

The answer to this question is that CFMC is not required to report anything directly to the NPDB. At the discretion of CFMC, they can report to the Board of Medical Examiners (BME), who in turn report to the NPDB. A representative of CFMC said that nothing has been reported to the BME as of March 31, 1992.

*For more on the NPDB, see the following page...*



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# Six and a Half Really Good Reasons to Blow Up the National Data Bank

*The following article is an editorial that originally appeared in Illinois Medicine and is reprinted by permission.*

*Unlike wine, cheese and teenagers, the National Practitioner Data Bank does not improve with age. Annual resolutions directing the AMA to influence and control it have turned into impassioned pleas from those who want to dismantle it. Here are six (and a half) reasons why they're right.*

**1. The only people who support the Data Bank are employed by the subcontractor who runs it.** The Data Bank seems to be universally loathed by almost everyone else. Doctors hate it. Hospitals hate it. Insurance companies hate it. Congress probably doesn't hate it yet, but they will. See No. 2.

**2. The program is way over budget and looks to continue that way.** The program's cost is scandalous. Originally projected by be self-supporting at \$2 per hospital inquiry, the Data Bank tripled its fee to hospitals within the first year, to \$6.

**3. The Data Bank has never met a deadline it couldn't miss, and**

**4. Its results are riddled with errors.** The program's execution is close to criminal. Files are routinely lost, errors in data input abound and the turnaround time has stretched far beyond the promised deadlines. The bureaucratic swamp that engulfs almost any government project has found its primeval source in the Data Bank. Summed up, it's a fatally flawed concept executed at a level of efficiency that makes the Post Office look good.

**5. It could get a whole lot worse.** You ain't seen nuthin' yet. The Data Bank is now considering reporting not only malpractice settlements and awards, but also open claims. Information in open claims is highly confidential; it is imperative that it be protected, to assure the privacy of patients and physicians alike. And our legal system

is such that anyone can sue anyone else for anything, no matter how frivolous. The concept of "innocent until proven guilty" is compromised by reporting open claims.

**5, (continued). It gets worse.** Now that the Data Bank is "up and running," you should pardon the expression, special interest groups are pushing for access to its information, however inaccurate it might be. Chief among these are the Ralph Nader-like public action groups that think it would be swell if the public could access the data.

The other group that would like—desperately—like to get its hands on the data is our old friend, the plaintiffs' bar. These attorneys claim information in the Data Bank is vital to building cases and compensating their injured patients.

**6. It's not necessary.** In addition to being hideously inefficient, the Data Bank is duplicative of state medical licensing and disciplinary boards. These agencies already do what the enabling legislation intended the Data Bank to do: prevent physicians with records of negligence or criminal activity from obtaining new licenses in other states without revealing their pasts.

So the biggest question about the Data Bank is not What? or Where? or even, for the masochistic among us, How?

It's Why? Why bother? Why put ourselves and our hospitals through this? Why not let the state boards to their job?

Why not get rid of the Data Bank?





**COLORADO**  
DEPARTMENT  
OF HEALTH

CA Chrvala, MF Crepeau, W Todd, W Math, GA Hurlburt, M Nadel;  
Cancer Control Program, Colorado Department of Health

## Breast Cancer Screening Results and Follow-up for Colorado Women:

*"A total of 152 breast cancer cases have been identified since the beginning of the project."*

The Colorado Mammography Advocacy Project (CMAP) is a state-wide breast cancer screening surveillance system operated since November 1989 by the Cancer Control Program of the Colorado Department of Health. Funded by the Centers for Disease Control, CMAP has three primary objectives: 1) promotion of adherence to routine breast cancer screening including mammography and clinical breast exam; 2) documentation of diagnostic follow-up for women with abnormal screening results; and 3) promotion of state-of-the-art quality assurance standards for mammography equipment throughout Colorado. Women become members of CMAP when they have a mammogram at one of 20 participating mammography centers located throughout Colorado. All participating centers undergo an on-site quality assurance evaluation to assure that the technical quality of all exams adheres to the standards of the American College of Radiology.

To date, over 41,000 screenings have been reported to CMAP and more than 36,000 women have enrolled in the project. The number of screenings exceeds the number of women because a significant proportion of women have had more than one mammogram. Standardized data concerning demographics, breast cancer risk factors, screening history, mammographic results, rescreening recommendations, and diagnostic follow-up are collected. A profile of CMAP members shows that approximately 15% of the women are 40 or younger; 33% are 40 to 49; 27% are 50 to 59; and 25% are 60 or older. Analysis of the data reveals that

13.8% of the women have a first degree family history of breast cancer and 3.2% have a previous personal history of breast cancer. Over 16% of the cases self-report the presence of some kind of symptom such as a breast lump, breast pain or swelling.

Standardized categories are used to record mammographic findings and radiologists' recommendations for follow-up. The four categories of mammographic findings are: *No Significant Abnormality (NSA)*, *Abnormality: Probably Benign (APB)*, *Abnormality: Indeterminant (Indet.)*, and *Suspicious for Cancer (S Ca)*. The distribution of mammographic results is as follows:

81.3% NSA; 14.5% APB; 3.6% Indet; and 0.58% S Ca. This distribution varies across the participating facilities with greatest variation evident for the NSA and APB categories. Specifically, the range across mammography centers for NSA findings is 68.6% to 85.9% and for APB findings, 10.7% to 25.6%. A range of 1.5% to 8.1% is observed between facilities for the Indet. category and 0.19% to 2.7% for S Ca.

The majority of the women (85.2%) receive recommendations for routine rescreening in 12 or more months. Diagnostic follow-up recommendations for the remaining 14.8% include clinical breast exam (31.4%), repeat mammogram in 4 to 11 months (36.6%), additional views (12.6%), ultrasound (21.3%), and surgical consult (11.7%). Recommendations for follow-up vary according to mammographic findings, mammography centers and patient characteristics such as age and breast cancer risk factors.

# Preliminary Analysis of Data From The Colorado Mammography Advocacy Project;

*"...a number of diverse factors...impact the process of decision-making for diagnostic follow-up."*

A comparison of completed diagnostic follow-up procedures and radiologists' follow-up recommendations demonstrate significant variation by mammographic findings, type of screening facility and patient characteristics. For example, the overall completion rate for radiologist recommended ultrasound is 43.2%. Across the four categories of mammographic findings, completion rates for recommended ultrasound is zero for women with S Ca findings; 26.7% for NSA findings; 43.8% for Indet results; and 51.3% for women with an APB mammographic interpretation. Follow-up procedures completed in lieu of a recommended ultrasound include: repeat mammogram (5.9%); clinical breast exam (45.1%); additional views (6.3%); surgical consult (20.8%); other procedures (10.3%); and no follow-up (11.6%).

Slightly less than three quarters (72.1%) of women recommended for surgical consult received such an evaluation. Of these, 79.4% were biopsied and no biopsy was performed in the remaining 21.6%. Analysis of surgical consult completion rates by mammographic findings reveals a 73.4% surgical consult completion rate for women with NSA findings and 66.6% for those determined to be APB. Actual biopsy rates of 81.8% and 63.6% were observed with NSA and APB findings, respectively. Similarly, the surgical consult completion rates were 83.8% for women with Indet findings and 89.3% for those with S Ca results. Actual biopsy rates for women with Indet mammographic findings was 84.7%, and 90.7% for the S Ca group. For the 124 cases not receiving recom-

mended surgical consult, 11.3% had a repeat mammogram; 37.1% a clinical breast exam; 6.4% additional views; 6.4% ultrasound; 6.4% have undergone other procedures; and 32.3% received no follow-up.

Almost 20% of the women in diagnostic follow-up have undergone biopsy. Of these, 39.1% were recommended on the basis of initial mammographic results and 60.9% were based on clinical findings and/or patient demand. Positive biopsy rate for radiologist recommended biopsies is 27.3%. This decreases to 7.1% in those instances where biopsy was not recommended on the basis of initial screening mammogram results.

A total of 152 breast cancer cases have been identified since the beginning of the project. Less than 5% of these cases occurred in women 40 years or younger; 29.8% were in the 40 to 49 year age category; 27.4% were between 50 and 59 years; and 37.9% were 60 and older. Almost 20% of women with malignancies reported a previous personal history of breast cancer and 22.1% had a first degree family history. Analysis of completed treatment procedures for breast cancer cases reveals that 67.6% have undergone mastectomy while 24.8% have undergone lumpectomy. Almost 15% of the breast cancer cases have received chemotherapy; 22.3% have received radiation and 16.6% received hormonal treatment.

These data clearly demonstrate that a number of diverse factors, in addition to initial mammogram results, impact the process of decision-making for diagnostic follow-up. Further research

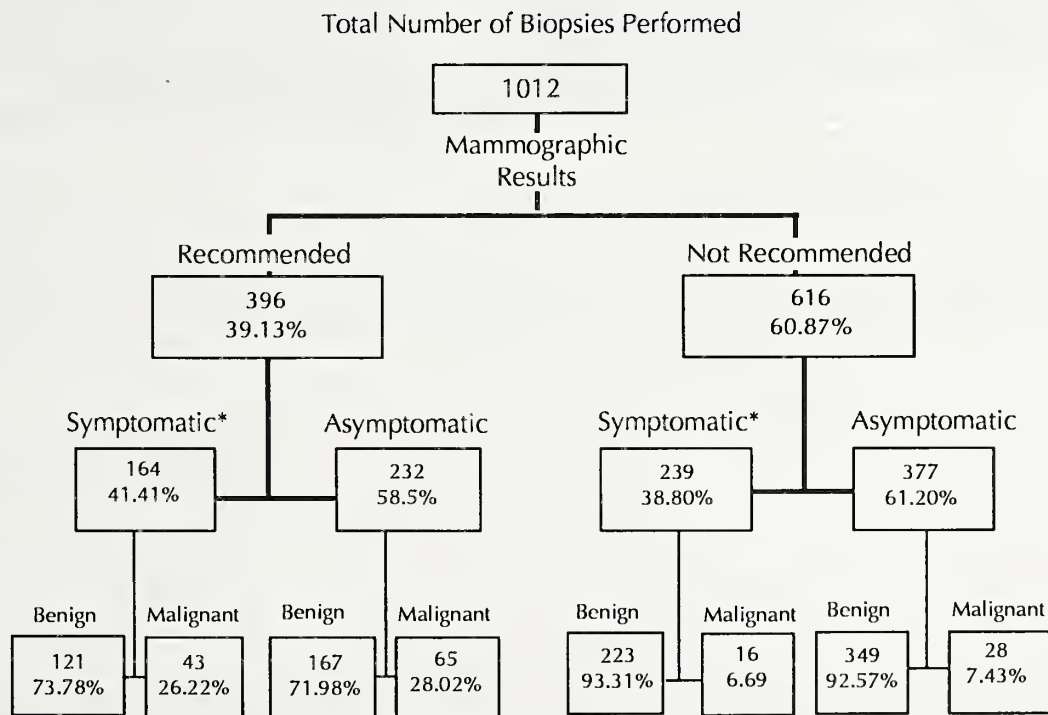


is needed to better understand this process. The Cancer Control program is working with an advisory committee comprised of radiologists, oncologists, surgeons, representatives from COPIC and Comprecare, and mammography center personnel to review the data and help guide future analyses.

Analyses of the information provided by CMAP can better help us understand the role and contribution of screening mammography in Colorado's breast cancer control effort. CMAP supports the efforts of the health care community to follow-up women with abnormal screening results and promote routine breast cancer screening. CMAP

is the only project of its kind in the country. Results from the CMAP database have been presented nationally to the National Cancer Institute and the Centers for Disease Control and will be presented at the upcoming 25th National Breast Cancer Conference sponsored by the American College of Radiology.

### Colorado Mammography Advocacy Project



Total Malignancies: 152

\*Based on patient self-report

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A monthly report of current and on-going activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.

May, 1992

**COUNCIL ON MEDICAL SERVICE** is looking for new members. Chaired by Dr. Mary Jean Berg of Ordway, the Council is charged with "studying the social and economic aspects of medical care which are influencing the practice of medicine; and on behalf of the public and the profession, suggesting means for the timely development of services in a changing socio-economic environment."

The Council meets 4-5 times per year on Friday evenings at 5:30. During the last two years the Council has been addressing the issue of health care in rural areas. These meetings have been held on Fridays to accommodate members from outside the metro area.

CMS President Harrison G. Butler, III, MD has asked that this group begin to study the implications of practice parameters as recommended by the AMA and compare them with a program of "competence testing."

The following committees serve under the purview of the Council: Emergency Medical Care Physicians Advisors Committee, Committee on the Medical Indigent and the Data Commission Task Force. Actions of the committees are referred to the Council for approval.

If you are interested, please contact Dr. Berg at (719) 267-3503 or Marilyn Barton or Ellen Stein at CMS, (303) 779-5455 or 1-800-654-5653.

# Straight Talk

An educational magazine for Teens  
about AIDS/STDs

may be ordered by writing:

Colorado Medical Society

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Denver CO 80217-0550

or by calling Lynn Livingston at  
(303) 779-5455

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1-800-654-5653

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## HIGHLIGHTS OF THE BOARD OF DIRECTORS MEETING, MARCH 27, 1992

### CMSA

Ms. Diane Duffy-Glismann, President, reported on the many worthwhile projects which the local Auxiliary organizations have been involved with throughout the state.

### AMA Delegation

Dr. Robert McCartney, AMA Alternate, discussed the issues which the Reference Committees at the AMA Interim Meeting in December had debated.

### Medical Student Component

Mr. Stephen Batuello reported that membership in the Student Component is increasing and that the group is working on a Health Care Reform plan.

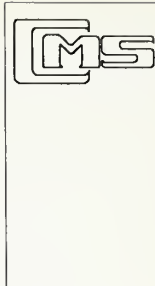
### Board of Directors Task Force

Regional meetings are being planned which will allow for CMS members to participate in the discussions and help formulate Health Care Reform policy for the Colorado Medical Society. A total of 8 meetings are planned throughout the state during the months of April, May and June plus one in July during the Leadership Conference. After obtaining input from these meetings, the Task Force will prepare a final document for presentation to the House of Delegates in September.

### Appointment

Dr. Robert D. McCartney was appointed to fill the vacancy created by Dr. Robert Hartley's resignation from the Colorado Health Policy Council.





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*continued on following page*



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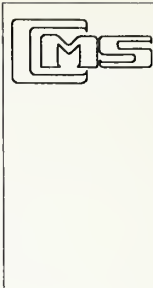
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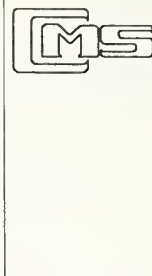
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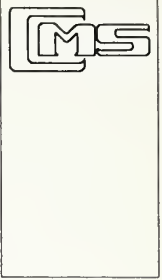
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# An expensive charting system is one that *doesn't* work.



**Subjective:** "The Plaintiff's husband had his first embolism  
21 months ago."

**Objective:** "Doctor, please show the COURT that  
record in your chart."

**Assessment:** "Oh ... #@\$#@\* .....  
..... I can't find it!"

**Plans:** ..... Call BIBBERO!!!

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## Small Area Analysis Project

The Colorado Hospital Association and the Colorado Medical Society are working cooperatively on the Codman Small Area Analysis project. This project utilizes CHA's discharge data in conjunction with the Codman software to look at variations in medical service utilization across geographic areas, in this case, hospital market areas. The Colorado Medical Society has primary responsibility for implementation of this project. An Advisory Committee has been developed to provide direction for the project.

Small Area Analysis is an educational tool for beginning to explore variations in utilization of medical services. It is hoped that the medical community, in cooperation with the project's advisory board and perhaps future study groups, will work together in the analysis and understanding of this information.

The Codman software gives us access to an incredible range of data. We can address variations in utilization at the level of major diagnostic categories, DRG's and procedures. We can explore access issues and rural vs. urban differences and their impact on services. The project Advisory Committee is in the process of determining where to initially focus our efforts and how to best involve the medical community.

While there are many issues to be addressed, this project has tremendous potential to assist the medical community in achieving a better understanding of practice patterns throughout the

state, why variations exist, and, when appropriate, changes that may be indicated.

If you have suggestions or questions regarding participation in and development of this project, please call Ellen Stein or Sandra Maloney at the Colorado Medical Society, 779-5455 or 1-800-654-5653. Thank you.

## Immunization Booklets

Last February, the Colorado Medical Society received a limited supply of camera-ready copies of the new Vaccine Information Pamphlets for MMR, DTP and OPV. We sent forms to physicians who had previously received immunization consent forms from us. They are to be duplicated for use in the offices.

We recently learned that Hospital Shared Services is offering copies of the completed booklets at a cost of \$15 per hundred, plus applicable freight charges and sales tax. The minimum order is 100. To place an order, call (303) 455-1420. All orders will be shipped within 3 days of receipt.

To receive one free camera-ready copy, call Lynn Livingston at CMS (303) 779-5455 or Nedra Freeman at the Colorado Department of Health (303) 331-8323.

## Colorado Health Professions Loan Repayment Program now fully implemented

*Richard L. Call, DMD, MS  
Executive Director, SEARCH/AHEC  
program*

The University of Colorado Health Sciences Center Health Professions

Loan Repayment Program is now fully operational and has begun granting awards to communities and health professionals throughout the state. With approximately \$200,000 of resources available, the program is intended to assist communities in the recruitment and retention of needed health personnel. As previously reported, physicians who wish to take advantage of this funding to repay educational loans, must meet the following criteria:

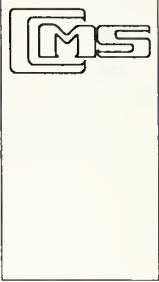
1. Practice primary care (family physicians, general internal medicine, OB-GYN, pediatrics) on a full-time basis in a federally designated Health Professional Shortage Area.
2. Be willing to participate in the Medicaid/Medicare program in Colorado and,
3. Be willing to practice in the community for at least two years.

A dollar-for-dollar community match must also be provided by the sponsoring public or non-profit community affiliate. Physicians interested in participating in the program should contact the SEARCH/AHEC Program at the University of Colorado Health Sciences Center (303) 270-5885, or their regional AHEC office.

## Help for Hospital Patients Who Smoke

The American Association for Respiratory Care (AARC) has developed a bedside smoking cessation treatment program for hospitals called the Nicotine Intervention Kit (NIK). Respiratory therapists evaluate patients for the medical diagnoses of nicotine





dependency and nicotine withdrawal. The patient's physician then determines if the patient meets the criteria for dependence. The service must be ordered by a physician in order to recover costs. Treatment for nicotine dependency is considered part of the patient's program for treatment of admitting diseases.

Louise Nett, a Respiratory Therapist at Presbyterian/St. Luke's Medical Center was instrumental in the development of the Kit. Contact her for more information at 839-6817. The NIK is available from AARC for \$50.

## AMA Wants to Oversee CME

The American Medical Association has proposed that it take over operation of the Accreditation Council for Continuing Medical Education (ACCME). The Council oversees most accrediting of organizations who offer CME. It is currently operated by the Council of Medical Specialties (CMSS) on behalf of the seven member organizations that run it, including the AMA.

CME activities have come under scrutiny recently, in view of charges that large corporations, especially pharmaceutical manufacturers, skew the information process by sponsoring CME events or paying physicians to speak on topics which would benefit sales of their products. Other questions have arisen over gifts to physicians, ranging from pens and prescription pads to cruise "conferences" and other large promotional items.

ACCME has begun taking steps to

curb excesses in this area. In March, it approved a random monitoring system for CME programs. This received impetus from Food and Drug Administration concerns about the distinct line between education and promotion. The Council has also formed a long range planning committee.

Hearing of the AMA proposal, CMSS Chairman Robert Taylor, MD asked the AMA to "let the ACCME carry out its own planning process before we take any precipitate action."

AMA Executive Vice President James S. Todd, MD told other ACCME parents, "We have an immature mechanism to monitor and enforce our standards."

AMA Senior Vice President for Medical Education and Science, M. Roy Schwarz, MD defended the AMA against charges of arrogance saying, "Arrogance is not the intent of the proposal. We see a need and we're willing to help meet it. It's not an ultimatum, it's an offer."

Those charges stem largely from the content of the AMA proposal, which calls for AMA to contribute \$250,000 per year for two years, office space in the AMA Headquarters building, assistance from AMA personnel, AMA media coverage of CME and establishment of a CME Institute.

Dr. Todd even offered to have AMA CME Director Dennis Wentz, MD work with the accreditation council, though some "CME insiders," according to a story in *American Medical News*, saw this as an attempt to move Dr. Wentz into the power vacuum

created by the recent resignation of CMSS Executive Vice President Richard Wilbur, MD.

Whatever the decision on this proposal, it is likely to have far reaching consequences for CME in the United States. ACCME Chairman Stephen Jay, MD took a balanced approach, "CME should get input from a lot of sources and shouldn't have one organization dominating CME. [But] the AMA's proposal deserves attention. We shouldn't underestimate the role of the AMA in CME and graduate and undergraduate medical education."

## FDA Revising Draft Concept Paper

Major revisions are being made to the original draft concept paper affecting CME programs supported by pharmaceutical companies. The FDA received over 200 responses to the original document. We understand that the new version will be more flexible. Although the updated version was to be published by March, we have learned recently that it will not be available until June. For those interested in receiving a copy of the new guidelines, contact:

ATTN: Regulation of Drug Company Sponsored Activities in Scientific or Educational Contexts  
Division of Drug Marketing, Advertising and Communications (HFD-240)  
**Food and Drug Administration**  
5600 Fishers Lane  
Rockville, MD 20857



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**FAMILY PHYSICIAN;** Community Health Center seeks BC/BE Family Physician for group practice north of Denver. Loan Repayment opportunities. Duties include full Family Practice (including OB) with staff of seven physician. Comprehensive benefits, pail malpractice, CME, competitive salary, very attractive location. Please send CV or inquiries to David Myers, 1115 2nd Street; Fort Lupton CO 80621, or call (800) 388-HEAL. 6/0292

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# Ruminations

(def: to chew again what has been chewed slightly and swallowed; to **REFLECT**)

William S. Pierson  
Managing Editor

## Government's View of the Practice of Medicine

Excerpts from remarks of Newton Minow, Esq., in his report on the litigation of the American Medical Association v. Federal Trade Commission (FTC) re. the FTC complaint challenging the ethical principles applicable to advertising and solicitation by physicians.

(presented before the AMA House of Delegates, December 3, 1978)

"Before I give my report, however, I believe you will see a theme in it, and that is that some government officials do not see the practice of medicine as either a science or an art, which reminds me of a story —

It seems that a company chairman had been given a ticket for a symphony performance of Schubert's Unfinished Symphony. He could not go that evening and passed the ticket on to his management consultant. The next morning the Chairman asked how he enjoyed the performance. Instead of a few plausible observations, he was handed a memorandum which read as follows:

'For a considerable period, the four oboe players had nothing to do. The number should be reduced and the work spread over the whole orchestra, thus eliminating peaks of activity.

All twelve violins were playing identical notes. This seems unnecessary duplication and the staff of this section should be drastically cut. If a large volume of sound is really required it could be obtained through an electric amplifier.

Much effort was observed in the playing of demi-semi-quivers of eighth notes. This seems an expensive refinement and it is recommended that all notes should be rounded up to the nearest demi-semi-quiver. If this were done, it should be possible to use trainees and lower grade operators.

Further, no useful purpose is served by repeating the passage that has been played by the horns with the strings. If all redundant passages were eliminated, the concert could be reduced from two hours to two minutes.

In fact, if Schubert had paid attention to these small matters, he probably would have been able to finish the symphony.'

As men and women trained in a noble and learned profession, you are now on notice that parts of our government claim that the medical profession is not a profession but a business — and that health care is now the Federal Trade Commission's business. At a time when the President and many members of Congress are saying that our country is over-regulated, the FTC wants to regulate the practice of medicine. I read you one ominous sentence from the decision of the FTC Administrative Law Judge: *'Respondents will be permitted to participate in setting ethical guidelines for the conduct of their members after first obtaining permission and approval of the Federal Trade Commission.'*

1984 has arrived in 1978. You, the members of an ancient and honored profession, are not even to participate in setting your own ethical standards without first getting the permission and approval of the federal government. I don't have to tell you how much is at stake here, fundamental principles far beyond this particular case."





# COLORADO MEDICINE

June, 1992

Volume 89, Number 6

Official journal of the Colorado Medical Society "Advocating excellence in the profession of medicine"

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\*\*\*\*\*ALL FOR STATE\*\*\*\*\*

## Tennis, Anyone?

### Copper Mountain Resort - September 10 - 13, 1992

## SPECIAL ISSUE: 1992 Annual Meeting



**CMS Annual Meeting Golf Tournament**  
at Copper Mountain Resort  
September 10, 1992

**Entry Form**

Name \_\_\_\_\_

Address \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

While at Copper Mountain I will be staying at \_\_\_\_\_

I will be attending the meeting in the capacity of (check one)  
☐ Physician    ☐ Exhibitor    ☐ Spouse    ☐ Other

My golf handicap is \_\_\_\_\_  
 I will require rental clubs @ \$20

☐ USGA    ☐ Other  
☐ Left handed    ☐ Right handed

Four-somes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$51 must be received no later than September 1, 1992.

I prefer to be teamed with \_\_\_\_\_

Mail Entry Form and check for \$51 to Specialty Media, P. O. Box 36357, Denver, CO 80236. For additional info, call Tim Jackson at 303-986-5926.

## Tennis anyone?

John Winn, head tennis professional at Copper Mountain, will conduct a two-hour tennis clinic for CMS Annual Meeting attendees starting at 1:00 p.m. on Thursday, September 10. Mr. Winn brings 26 years of teaching experience to the aid of your tennis game. His teaching philosophy is: "Perfect practice equals improved technique equals success, and success in tennis is more than just winning matches. It's learning to play the game with skill and honor. In this way you can always plan WINning tennis."

At the clinic you'll have an opportunity to meet other CMS players and arrange matches following the clinic or through Sunday. Outdoor court fees are \$10/hour. Mr. Winn will gladly set up a round robin tournament if there is sufficient interest.

The cost for the clinic is \$20/person with a minimum of four and a maximum of eight players. Additional pros are available if we have more than eight. Clinics can also be conducted for children. Rental racquets are available through the Copper Mountain Athletic Club.

**Yes!** Enroll me (us) in the September 10 tennis clinic at Copper Mountain.

Name(s) \_\_\_\_\_ Component Society \_\_\_\_\_

☐ Physician    ☐ Spouse    ☐ Child    ☐ Medical Executive    ☐ Exhibitor    ☐ Other

Please mail this entry form and your check for \$20/person by August 21, 1992, to Specialty Media, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

## COLORADO MEDICAL SOCIETY

### TENTATIVE 1992 Annual Meeting Schedule Copper Mountain, CO September 10-13, 1992

Activity		THURSDAY, SEPT. 10		SATURDAY, SEPT. 12	
9:00 am		18 hole Golf Tournament		7:00 am	CMS Office opens
1:00 pm	2:30 pm	Finance Committee		7:00 am	1:30 pm Registration
2:30 pm	4:30 pm	Board of Directors		7:00 am	7:50 am Continental Breakfast
3:00 pm	6:00 pm	CMS Office open		7:00 am	12:00 pm Exhibits open
5:00 pm	10:00 pm	Exhibitor Set Up		8:00 am	1:30 pm Educational Program Includes break and lunch
6:00 pm	7:00 pm	Reception: Political Convention Roaring '20s Style			Recreational Activities (golf, tennis, horseback riding, biking, fishing, walking, etc.)
7:00 pm	8:30 pm	Dinner: Political Convention Roaring '20s Style		1:30 pm	Exhibits open
FRIDAY, SEPT. 11				4:00 pm	6:00 pm Hosted Bar
7:00 am		CMS Office opens		4:30 pm	6:00 pm Inaugural Address
7:00 am	5:00 pm	Registration		6:00 pm	7:00 pm Presidents' Dinner/Dance
7:15 am	8:45 am	Congress of Medical Specialties		7:00 pm	11:30 pm Copie Dessert Reception
7:15 am	8:45 am	Unified Grievance Committee		8:30 pm	11:30 pm
7:30 am	8:30 am	Reference Committee Breakfast		SUNDAY, SEPT. 13	
8:00 am	12:00 N	Exhibits open		7:00 am	CMS Office opens
8:30 am	9:00 am	Credentials Committee		7:00 am	12:00 N Registration
8:30 am	10:00 am	CMSA BOD Breakfast		7:00 am	8:30 am Component Caucuses
9:00 am	9:30 am	Opening Session HOD			Arapahoe
9:30 am	11:45 am	General Membership Meeting			Aurora Adams
10:00 am	10:30 am	Coffee break			Boulder
10:00 am	11:30 am	CMSA General Meeting			Clear Creek Valley
12:00 N	1:30 pm	COMPAC/CMSA Luncheon			Denver
12:00 N	1:30 pm	Hospital Medical Staff Section Luncheon			El Paso
1:30 pm	4:15 pm	Shopping trip to Silverthorne for spouses			Larimer/Weld
1:30 pm	7:00 pm	Exhibits open (refreshments)		8:00 am	8:30 a.m. Credentials Committee
1:30 pm	2:30 pm	Copic Risk Management		8:00 am	9:00 am CMSA Gavel Club Breakfast
1:30 pm	2:30 pm	Copic Risk Management		8:30 am	12:00 N Closing Session House of Delegates
1:30 pm	4:00 pm	Reference Committee		9:00 am	11:00 am CMSA Program
1:30 pm	4:00 pm	Reference Committee		NOTE: Dress for Annual Meeting	
2:30 pm	3:30 pm	Copic Risk Management		Thursday evening reception/dinner: Roaring '20s or casual	
2:30 pm	3:30 pm	Copic Risk Management		Friday: business attire	
3:30 pm	6:00 pm	Reference Committee		Saturday morning: casual	
3:30 pm	6:00 pm	Reference Committee		Saturday reception/dinner: coat and tie/dressy business attire or cocktail dresses	
5:30 pm	7:00 pm	Exhibitor Reception		Sunday: casual	
6:30 pm	7:30 pm	Colorado Society of Internal Medicine Women in Medicine Reception			
6:30 pm	7:30 pm	attendees invited			
7:00 pm	8:30 pm	"Gone But Not Forgotten" Dinner for CMS past presidents, past members of the Board of Directors (1982-83 through 1991-92) and their spouses — by invitation			





# COLORADO MEDICINE

June, 1992

Volume 89, Number 6



## Cover Story

You and the entire family can find your special interest during this most beautiful time of the year in Colorado's Rockies. Tennis, hiking, golf, fishing, lounging in the autumn sun and colors. Bring the family and make it a memorable trip to combine your professional association with family relaxation.

## In This Issue...

- All of the necessary details of the Colorado Medical Society Annual Meeting of the House of Delegates and special planned activities and programs of the CMS Auxiliary.

You'll find hotel reservation details, meeting registration, the preliminary schedule and the many activities offered by Copper Mountain Resort and the surrounding countryside.

Colorado Medical Society has, for many years, published the Annual "Physician's Directory" as an integral part of *Colorado Medicine* magazine. Thanks to the use of the book and the continued growth of the CMS membership, the "Physician's Directory" has outgrown the magazine parameters.

- CMS membership will be receiving, by a separate mailing, the 1992 Resource Book and "Physician's Directory" within a matter of days. This year's edition will be more helpful than past issues for a host of reasons.

Remember, each CMS member receives a copy of the Resource Book at no cost; however, additional copies of the publication can be purchased by members for \$15.00 additional. You can order the additional copies through the CMS offices.

## It's That Time of Year Again



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

**"Already?"** you say, "It can't be!" But it is. Time to register for the Annual Meeting.

We have lots of educational and fun activities scheduled for you this year, in addition to the business meetings that set CMS policy and drive all our activities for the year.

Did you know that almost everything the CMS staff, Councils, Committees and Task Forces do is determined by resolutions presented at the meetings of the House of Delegates? Not only that, but each member has an equal opportunity to present resolutions for consideration, to testify before a Reference Committee (or even serve on one) and to have a dramatic impact on the direction CMS will take on important issues in the coming year. The Colorado Medical Society really is a member driven organization.

Look over the enclosed information, select those activities and meetings in which you would like to participate and fill in your registration form. You then may mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455, ext. 430 or 427) or even FAX it to us (at 303/771-8657).

Get your registration in quickly. There are limited spaces available for some programs. Notice also that you will need tickets for all meal functions. We must remain fiscally responsible by getting an accurate count of those who will attend these functions.

I look forward to seeing you in Copper Mountain!

*Sandi*

Sandra L. Maloney





# What to do at Copper Mountain

by Gil Maestas, II  
for Colorado Medicine

## *Activities for the whole family at the 1992 Annual Meeting*

September 10th thru 13th has been reserved for The Colorado Medical Society Annual Meeting. Please plan to attend and enjoy the beautiful surroundings. During the month of September the Colorado Rockies are alive, and opportunities for fun in the sun are limitless. This year's gathering will be held at the Copper Mountain Resort. The facility provides spacious meeting rooms, exhibit areas, comfortable sleeping rooms, as well as the Copper Mountain Racquet & Athletic Club. A swimming pool, exercise room, sauna, basketball court and aerobics instruction are provided free of charge. The resort also has indoor and outdoor tennis available at a rate of \$16.00 and \$10.00 per hour respectively. Racquetball courts are also available at a cost of \$8.00 an hour. After a long day of meetings or exercise, treat yourself to a relaxing rub. The resort has a massage therapist on duty at the rate of \$45 per hr, or \$25 per half hr.

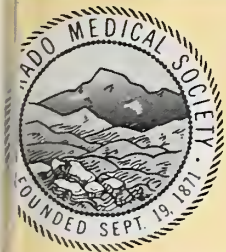
Hiking and Mountain bike enthusiasts please take note. The Copper Mountain area provides an abundance of territory to be explored. Trails for both activities range from moderate and easy to very advanced. A paved trail is also available for roller blade enthusiasts. In addition to the activities mentioned, the Copper Mountain Resort can provide or arrange a number of ways to spend free time. Here are a few examples:

Jeep tours, Free Chairlift Rides, Free Paddleboating/Kids Fishing, Fly Fishing Lessons, Bike Rentals, Hot Air Balloon Rides, Canoe Trips, Volleyball,

Horseshoes, Leadville Train Rides, and Golf on the Copper Creek Golf Course. For more information please contact the Resort Activities Desk (ext. 6322).

For those bringing children, the Copper Mountain Resort has started the Copper Adventure Mountain Program (CAMP). This summer camp has been designed specifically for kids ages 5-12. It is a high energy program, providing a full day of supervised activities. Kids will swim, go on hikes and nature walks, or play softball or capture the flag. Other activities may include fine arts, chairlift rides, field trips to a museum or water park. Tennis or golf lessons may be arranged upon request at an additional charge. This program normally runs thru the summer months and concludes on August 28th. If at least 10 kids are interested, the resort has offered to extend the program for The Colorado Medical Society meeting at the price of only \$20.00 per day. Reservation deadline is Aug. 21. In room evening child care, and group sitting is also available: \$6/hr 1st child - \$1/hr for each additional child per family. For more information please contact Sandy Finney at The Colorado Medical Society, 779-5455 (ext. 406). We hope that your stay in Copper Mountain will be an enjoyable experience. If we can help in any way please don't hesitate to ask.





# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

Volume 89, Number 7

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July, 1992

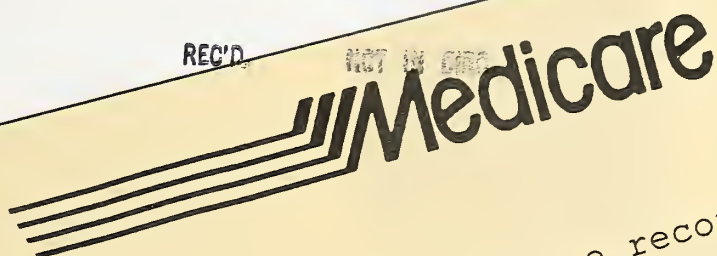
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STACKS

STACKS



"Our current Medicare record  
has you as being deceased."

If you believe this  
information is not correct,  
please call..."

*"In order for any health care program to be effective it must, at the very least, be humane."*

Harrison G. Butler, M.D., President  
Colorado Medical Society

## In This Issue:

Lawmakers say they have no choice but reform health care....by Harrison G. Butler III, M.D., President, CMS  
WAIT! What are we trying to reform?.....by John F. Farrington, M.D., past-president, CMS  
Colorado Patient Autonomy Act .....by Karen B. Best, Esq.  
CLIA effective September 1 - Seminars begin in Denver in July .....Colorado Dep't. of Health  
ADA - Its impact on employers.....by Myron Treber, Human Resources, Copic  
New CMS Members



# Goals Vs. Performance



## **1981 Goal:**

**Work Toward Eventual Resolution of the Major  
Professional Liability Problems in Colorado**

## **1992 Assessment:**

Goal not yet reached, but we're well on the way. Item:

- We were a major organizer of and participant in coalition efforts which resulted in passage of the Health Care Availability Act of 1988 and several other tort reforms. Many now believe that it was the most comprehensive package of health-care-related tort reforms in the nation.



## **The bottom line for Copic:**

provide Colorado physicians and, indirectly, the people  
of the state with professional liability insurance which  
is affordable, equitable and fair.

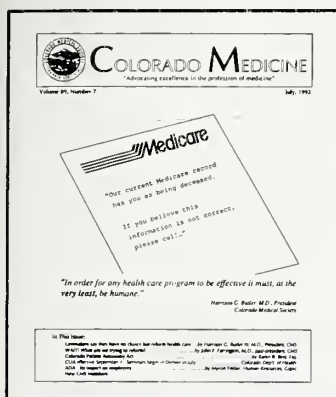




# COLORADO MEDICINE

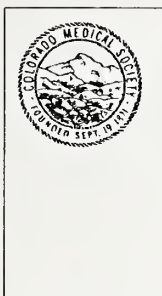
July, 1992

Volume 89, Number 7



## COVER STORY

Only a computer could call someone dead and ask if she had any questions. But couldn't a human straighten it out? Apparently not. See p. 211



## DEPARTMENTS

- 211 President's Letter
- 213 Letters
- 215 Executive Director's Update
- 226 Health Care Financing
- 228 Committee Update
- 229 Medical News
- 232 Ruminations
- 244 New Members
- 246 Classified Advertising

## In This Issue...

- 211 **Health Care Reform:** Let's put control at the state level!  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 216 **The All-Payer Alternative—**Controlling Costs Through Competition  
*J. Stephen Kroger, MD*  
*Trustee, American Society of Internal Medicine*
- 218 **Wait! What Is It We're Trying To Reform?**  
*John F. Farrington, MD*  
*Past-President, Colorado Medical Society*
- 220 **Mini-Internship:** A Vital Role  
*Gil Maestas, II*
- 222 **Autonomous Medical Treatment Decisions**  
*Karen B. Best, Esq.*  
*Associate, Montgomery Little Young Campbell & McGrew*
- 233 **Safety of Blood Donations—**An Open Letter  
*W. C. Dickey, MD*  
*CEO/Medical Director, Belle Bonfils Memorial Blood Center*
- 234 **Participation 92!—**Your chance to get involved  
*W. Ben Galloway, MD*  
*Patti Brown*  
*Co-Chairmen, Participation '92*
- 240 **CLIA—**Laboratory Regulations Take Effect September 1  
*Judy Donaldson, MS, MT*  
*Division of Laboratories, Colorado Department of Health*
- 242 **The ADA and Your Employees**  
*Myron L. Treber, Director, Human Resources*  
*Copic Insurance Company*



# COLORADO MEDICAL SOCIETY

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor





Harrison G. Butler, III, MD  
President, Colorado Medical Society  
1991-1992

## Health Care Reform: Let's put control at the state level!

*One of every four born in Colorado is a Medicaid baby.*

Health care reform continues to be the "hot topic" in Colorado. I recently had an interesting conversation with State Rep. Scott McInnis (R - Dist. 57) when he "hitched" a ride with me on my flight back to Durango. He is running for Congress in the spot vacated by Ben Campbell and wanted to discuss health care reform.

There is absolutely no question that there will be some type of reform of health care. From the legislator's standpoint, there's no choice. In Colorado, medicine is second only to education as the most costly budget item. However, according to Rep. McInnis, the school budget is fairly predictable and, therefore, plans can be made to accommodate growth.

The costs incurred by Medicaid are totally out of control. This theme was echoed Thursday at the last meeting of the Health Data Commission by State Rep. Tony Grampsas (R - Dist 25). Rep. Grampsas feels a Medicaid crisis is here. I know the word "crisis" is overused when applied to health costs, but he told us that one of every four babies born in Colorado is a "Medicaid" baby. With the changes being discussed by "da feds," one of every **two** births in Colorado will be a "Medicaid" baby. One of the favorite habits of "da feds" is to mandate health coverage for increasing numbers of people, but NOT provide funds to

cover these people. This places an intolerable burden on our legislators, who are faced with balancing the state budget. Federal legislators, of course, are not bothered by small details such as balancing a budget (and judging by their recent behavior they won't do so soon!).

Physicians have to be part of their reform process. If we are not involved, the outcome may well be disastrous. I can personally attest that other special interest groups such as the trial lawyers, the elderly, the chiropractors and others are wading in with political influence and plenty of money.

The Colorado Medical Society is now a major player in this process. Sandi Maloney and I have now met nine times with physicians over the state, providing them an opportunity to give their ideas and opinions on health care. I was impressed by the quality and quantity of their thoughts, but was disappointed in the attendance at these meetings, especially in the Denver area.

However, the physicians who attended were quality people, and I thank them. For those of you who chose to stay away, my condolences. I was surprised and impressed that the reimbursement issues were not as important to physicians as quality care issues. Also, a "basic care package," universal coverage and portability were major concerns.

Personally, I hope that through this

# Health Care Reform

(from previous page)

process we can convince "da feds" to allow **local control** of health care programs. We must keep the control at least at the state level. The federal bureaucracy is simply not able to manage a program as important as health care of individuals. A case in point is a patient I have cared for: the patient asked me for help dealing with Medicare. She received a letter (see below); as you can see, she has been declared "dead" by Medicare and was then urged to call an "800" number if she had any questions. As

you can probably guess, the phone calls and letters have only yielded referrals to other departments, excuses and brain flatus. I called Grant Steffen, M.D. at the Blue Cross-Blue Shield, the fiscal intermediary for Colorado Medicare. He was also shocked and dismayed by this process. He was very helpful, but he, too, has found it difficult to deal with those who oversee "da master file" in Maryland.

As of this writing, this patient remains officially "dead." I hope she

points out that she is "officially dead" next April 15, time to file her income tax return.

In order for any health care program to be effective, it must at the **very least** be humane. Mistakes will be made, but obviously the system must be able to correct mistakes without an act of God!

Stay tuned to **Colorado Medicine** as the results of the health care reform meetings will be published for your information.



06/03/92

CORRESPONDENCE CONTROL NO:  
RE: PATIENT'S NAME:  
MEDICARE CLAIM NUMBER:  
INTERNAL CLAIM NUMBER:

DEAR MS

YOUR LETTER HAS BEEN REFERRED TO ME FOR RESPONSE.

OUR "HEALTH INSURANCE MASTER RECORD" SHOWS THAT YOUR MEDICARE PART B COVERAGE WAS TERMINATED FEBRUARY 15, 1992. OUR CURRENT MEDICARE RECORDS UPDATE HAS YOU AS BEING DECEASED.

IF YOU BELIEVE THIS INFORMATION IS NOT CORRECT, PLEASE CONTACT SOCIAL SECURITY AT 1-800-772-1213.

SINCERELY,

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE.

SINCERELY,

MEDICARE SERVICES



# CMS Med Fax<sup>®</sup>

**AT PRESS TIME...**

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

CMS Med Fax<sup>®</sup>  
by *Montgomery Little Young Campbell and McGrew, P.C.*  
legal counsel to the Colorado Medical Society

---

## Physicians To Face Lower Reimbursement

### Legislative Changes Affect Your Practice

Over the strong opposition of the Colorado Medical Society, the 1992 Legislature passed (and Governor Roy Romer signed) HB92-1306, including a controversial section on Medicare/Medicaid reimbursement. The CMS Council on Legislation points out that this bill will likely make it harder for elderly and low income Colorado residents to find adequate, affordable health care.

Section 26-404 (b) (1) of the bill mandates that the Department of Social Services pay the *lower* of Medicare or Medicaid reimbursement for patients with dual eligibility. Since Medicare reimbursement does not even cover the physician's cost to treat the patient in many instances, and Medicaid usually pays even less, many physicians will be forced to stop subsidizing the medical care of these patients.

Until now the small Medicaid reimbursement acted as a sort of co-payment in these dual eligibility instances. With the passage of this measure, that small amount, or the Medicare amount, if it is even smaller, will be considered payment in full. Without dramatic cost shifting (not a palatable option to most) there will certainly be physicians who can no longer afford to provide quality medical care at cut-throat prices. This means that the elderly and poor who participate in these programs will face the increasingly difficult challenge of obtaining health care.

Of course, the CMS has encouraged its members to provide care to these unfortunate patients and most physicians recognize a sort of public trust to help patients from all walks of life, regardless of age or economic status. However, the medical community finds it increasingly difficult to bear the burden of indigent health care without some assistance from other sectors of society. This legislation puts even more of

that burden on physicians, while reducing the amount they are able to recover from social programs.

The CMS repeatedly expressed these concerns to the Department of Social Services, but to no avail.

Another controversial measure, which would have reformed methods for providing medical assistance to the indigent in Colorado, was SB92-65. The CMS lauded provisions of this legislation which would have guaranteed the poor and disadvantaged of Colorado subsidized help from the state and the provider community for legitimate medical needs. There were also good provisions for a study to develop a sound alternative state medical care plan. However, that would have required a waiver from the federal government because of changes in Colorado's participation in Medicaid, and CMS was very concerned that it also mandated withdrawal from the Medicaid program if that waiver was denied.

This would have placed the entire burden of providing for the increased number of poor mothers and children who have recently been added to the program on the taxpayers and physicians of Colorado. The estimated loss of federal funding is from \$500 to \$600 million. That cost would have to be shifted to the insured community and subsidized by the physician providers. Those physicians currently receive less than fifty cents on the dollar of their usual and customary fees from Medicaid anyway. Governor Romer avoided the throngs of angry constituents who might have jammed his office by vetoing this bill.

See inside this issue for more information on 1992 legislative matters, particularly redistricting and medical decision making legislation.



## Med Fax: Medico-Legal News

by Karen B. Best, Esq., an Associate  
with Montgomery Little Young Campbell & McGrew, PC

*This column is not legal advice, but is for general information only. For help with specific problems, readers should consult an attorney.*

### In the News:

**Social Services Policy Upheld.** The Colorado Supreme Court recently held that denying Colorado's low income mentally ill citizens access to Home and Community-Based Services, funded in part by the federal government through federal funds obtained under Medicaid waivers, and made available to elderly, blind, and disabled persons, does not violate equal protection or Section 504 of the Rehabilitation Act. Thus, Colorado Social Services is not obligated to provide these services to the low income mentally ill of this state. *Duc Van Le v. Ibarra*, No. 91SC189, Colorado Supreme Court, April 20, 1992.

**Joint Ventures Targeted by IRS.** Not-for-profit hospitals must terminate certain joint ventures with their medical staffs by September 1, 1992 or risk loss of their tax-exempt status. IRS Announcement 92-70.

**Halcion Stays on Market.** An FDA advisory panel voted 7-1 to allow Halcion to remain on the market with stronger warning labels. The recommended dose is not 0.25 milligrams.

**Heart Valve Claims.** Pfizer, Inc. has offered \$500 million to settle all claims arising from defective Shiley heart valves, several hundred of which have fractured.

**Lawsuit Warning.** California law now requires malpractice plaintiffs to give potential malpractice defendants 90 days notice of the plaintiff's intent to file suit. *Godwin v. City of Bellflower*, No. B055905, Cal. Ct. App., 2d App. D., May 5, 1992.

### Antitrust Action

A federal district court awarded a hospital and members of its medical staff more than \$450,000 in attorney's fees under the Health Care Quality Improvement Act of 1986 and Rule 11 of the Federal Rules of Civil Procedure (providing sanctions for filing unfounded claims), in a physician's unsuccessful antitrust challenge to the hospital's peer review activities. *Wei v. Bodner*, No. 89-1137 (AET), USDC for DNJ, April 13, 1992.

## Puerto Rico: Foreign or Domestic?

A California appeals court upheld the decision of the California Board of Medical Quality Assurance denying the application for a medical license of a graduate of an unaccredited medical school in Puerto Rico. The applicant argued that she should have been licensed under statutory provisions (which Colorado also has) allowing licensure of graduates of unaccredited foreign medical schools. However, the court held the Puerto Rican medical schools are not foreign medical schools and that graduates of those institutions would have to meet the same criteria for licensure as graduates of medical schools in the US. *Lopez v. BMQAC* No. B061468, Cal. Ct. App., Second App. D., May 13, 1992.

### Pharmacist with HIV

A DHHS administrative law judge upheld the Department's decision to terminate all federal funding (Medicare and Medicaid) to the Westchester County Medical Center, finding that the Medical Center had violated Section 504 of the Rehabilitation Act by discriminating against a pharmacist who had tested positive for HIV, and finding that the violation was the result of Medical Center policy rather than an isolated incident. The Medical Center was willing to hire the plaintiff on the condition that he not prepare intravenous solutions and that he work at a satellite facility. The Court ordered the hospital to hire the pharmacist without placing restrictions on him or forfeit \$107 million in federal funds. The hospital is appealing. *In re Westchester County Medical Center*, Decision No. 91-504-2, DHHS, D. App. Board, April 20, 1992.

### DHHS Can Fix Prices

A US District Court in New York upheld, on reconsideration, the dismissal of claims filed by hospital-based anesthesiologists against the Secretary of DHHS, challenging the implementation of the resource-based relative value scale (RBRVS) methodology for physician reimbursement. Under RBRVS, effective January 1, 1992, physicians who do not accept assignment of Medicare may not charge more than 120% of the recognized payment amount under RBRVS, and not more than 115% after 1992. The Court again held that the reimbursement scheme does not constitute a taking without due process of law. The court also concluded that, although hospital-based anesthesiologists may not be able to avoid serving Medicare patients, they do have a choice between practicing in hospitals and



serving Medicare patients at fees limited by the Medicare law, or not practicing in a hospital at all and charging fees that are not subject to the fee ceiling. *Garolick V. Sullivan*, 91 CV 4524, USDC S. Dist. NY, March 24, 1992.

## Income & Expense

Last but not least: According to the AMA, the average earned by physicians in 1992 was \$164,300. Surgeons (\$236,400), radiologists (\$219,400), anesthesiologists (\$207,400) and OB/GYNs (\$207,300) made the most, while pediatricians (\$106,500), and general and family practitioners (\$102,700) made the least. One quarter of the general practitioners made less than \$65,000. The average malpractice premium in 1991, for self-employed doctors was \$14,500, within a range from \$34,300 for OB/GYNs to \$4,500 for psychiatrists.

## Women in Medicine

The American Medical Association has designated September, 1992 as Women in Medicine Month, to honor women physicians practicing in the United States.

Women form an ever increasing portion of those in medical practice, yet their specific needs and desires are not yet fully addressed by a system designed by and for male physicians. To help correct this inequity, Rose Medical Center is hosting its second annual "Finding a Balance" conference for women physicians, August 14-16, 1992 in Vail, Colorado. The conference seeks to help female physicians find the balance between professional issues and personal choices.

The conference will bring together prominent women professionals to heighten awareness regarding health issues, relationships and professional development. *Martha Illige-Saucier, MD*, a Family Practitioner from Denver, Colorado, will be the Course Director. The faculty also includes *Judith Briles, PhD*, a Denver

author and consultant, *Frances Conley, MD*, Professor of Neurosurgery at Stanford University School of Medicine and Chief, Section of Neurosurgery at the Veterans Administration Medical Center in Palo Alto, California, *Joan Shapiro, MD*, a Psychiatrist in private practice in Denver, and author of *Men, A Translation for Women*, and *Loretta LaRoche*, a consultant in fitness, wellness and personal development from Plymouth, Massachusetts.

For more information on the conference, call 1-800-526-0278.

## Notice

El Paso County Medical Society has endorsed the educational seminars put on by the Copic Insurance Agency. Seminars on such topics as estate planning and retirement strategies will be presented in the Colorado Springs area.

For more information, call the Copic Agency at (303) 779-0044 or 1-800-421-1834 or Carol Walker at the El Paso County Medical Society, (719) 591-2424.

## Changes in Immunization Requirements

Effective July 1, 1992, according to the Colorado Department of Health, there will be changes in the laws regarding Measles, Mumps and Rubella vaccinations. Children in day care, seventh graders and college freshmen will be required to prove they have been immunized. There is also a new requirement for infants in day care to be vaccinated against *Haemophilus Influenzae* as a protection against meningitis.

Effective July 6, 1992, the federal Occupational Safety and Health Administration requires employers (including physicians) to make a hepatitis B immunization series available to their employees.

Watch *Colorado Medicine* in August for additional information on changes in vaccination requirements.

# CMS Med Fax

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

## **Medical Education Resources**

**Asthma and Allergy in the 1990s**

Jackson Hole WY

July 24-25, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

**Coronary Heart Disease Update**

Lake Tahoe NV

July 31-August 1 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

**Advances in Vascular Diseases**

Gatlinburg TN

August 6-8, 1992

(303) 798-9682 or 1-800-421-3756

## **U. S. Public Health Service**

**The Hidden Epidemic (HIV in low prevalence Western states)**

Red Lion Hotel, Denver

August 12-14, 1992

(303) 290-6476

## **Medical Education Resources**

**Neurology for the Non-Neurologist**

Vail, Colorado

August 14-16, 1992

Stephen E Mattingly (303) 798-9682 or 800-421-3756

## **Medical Education Resources**

**Asthma and Allergy in the 1990s**

Monterey, CA

August 14-15, 1992

(303) 798-9682 or 1-800-421-3756

## **Rose Medical Center**

**Finding a Balance for Women in Medicine**

Vail, Colorado

August 14-16, 1992

1-800-526-0278

## **Assault Survivors Assistance Program/Redirecting Sexual Aggression**

**Sexual Trauma: A Balanced Approach**

Vail, Colorado

August 28, 29, 1992

## **Lovelace Medical Foundation**

**Mammography Seminar**

Santa Fe, NM

September 7-11, 1992

Dawne Ryals, (404) 641-9773

## **Medical Education Resources**

**Arrhythmias: Interpretation, Diagnosis and Management**

Las Vegas NV

September 25, 26, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

**Advances in Vascular Diseases**

Atlantic City NJ

September 25, 26, 1992

(303) 798-9682 or 1-800-421-3756

## **Rocky Mtn College Health Association**

**Annual Fall Meeting**

University of Wyoming, Laramie, WY

September 25-26, 1992

1-800-448-7801 or (307) 766-2124

## **Colorado Fetal Alcohol & Substance Abuse Coalition**

**Prenatal Exposure to Alcohol & Drugs**

Colorado Convention Center, Denver, CO

October 2, 3, 1992

Heather Jones (303) 861-6838

## **Medical Education Resources**

**Advances in Vascular Diseases**

Orlando FL

October 9-10, 1992

(303) 798-9682 or 1-800-421-3756

## **Univ. of Calif. Med School Dept. of Radiology**

**Radiology in Africa**

Nairobi, Samburu, Kenya, Masai Mara

October 10-24, 1992

Dawne Ryals (404) 641-9773

CMS Med Fax is printed on recycled paper







*"[T]he essence of due process is fairness in procedure."*

May 8, 1992

Harrison G. Butler, III, MD, President  
Colorado Medical Society

Dear Dr. Butler:

On behalf of the Board of Medical Examiners, I extend my thanks to the CMS leadership for taking time to meet with representatives of the BME to discuss complaint review procedures.

We read with interest your reflections on the meeting that appeared in the April, 1992 issue of *Colorado Medicine*. You express the opinion that "there should be some measure of due process" at the investigative stage, suggesting that no due process exists at the present. In addition, you appear to be in favor of allowing both the physician and the complainant to appear before the Board's investigative panel before a decision is reached whether to go forward with formal proceedings.

For the record, and for the benefit of your readers, the Board has asked me to reiterate its feelings on this issue. First, the essence of due process is fairness in procedure. The Colorado Medical Practice Act and the Board's procedures are recognized nationally as a model with respect to due process. A physician who is the subject of a complaint, or whose conduct is otherwise on review by the Board, is promptly notified via the "20 day letter," and is offered an opportunity

to submit whatever information he or she desires the Board to consider.

The Board's only request is that those submissions be in writing, both to minimize opportunities for later misunderstanding and to create a record of the proceedings which establishes the basis for the ultimate decision reached by the Board. We would note that physicians disciplined by the Board frequently challenge the Board's decisions in the courts, and the courts regularly find that the Board has in fact provided due process to physicians beyond the minimum. Thus, the Board does not agree with any inference that its investigatory procedures lack due process.

Second, we would point out that allowing the complainant and responding physician to appear before the Board during the investigative stage, in effect, amounts to an informal hearing, with all of the pitfalls and none of the due process benefits that attend the current procedure set forth in the Medical Practice Act and the Colorado Administrative Procedure Act. In the Board's view, such informal hearings have great potential to undermine, rather than enhance, due process afforded to physicians.

In addition, there is the question of additional burden on Board members. Nine of the eleven members of the Board of Medical Examiners are practicing physicians; and the two public members have their own professional endeavors in addition to



their volunteer service to the Board. We very much appreciate your acknowledgment of the tremendous work load of the Board of Medical Examiners, along with the personal sacrifices Board members make in order to meet their obligations in service to the people of Colorado. If the investigative committees of the Board were to conduct several dozen "informal hearings" in a year's time, the demands on individual Board members would skyrocket astronomically. Such a procedure would stretch our system beyond its limits, to the point where it simply would not be feasible for a practicing physician to serve as a Board member. In effect, we would be taking a step toward the direction where only retired physicians or those not engaged in the active practice of medicine would have the time to serve on the Board; or perhaps the General Assembly would move toward a model where in physician Board members are full time civil servants, rather than practicing physicians who also serve as citizen Board members. Is that what the CMS really wants?

We appreciate your consideration of our position, and we very much appreciate your interest in the Board. Thank you for your support.

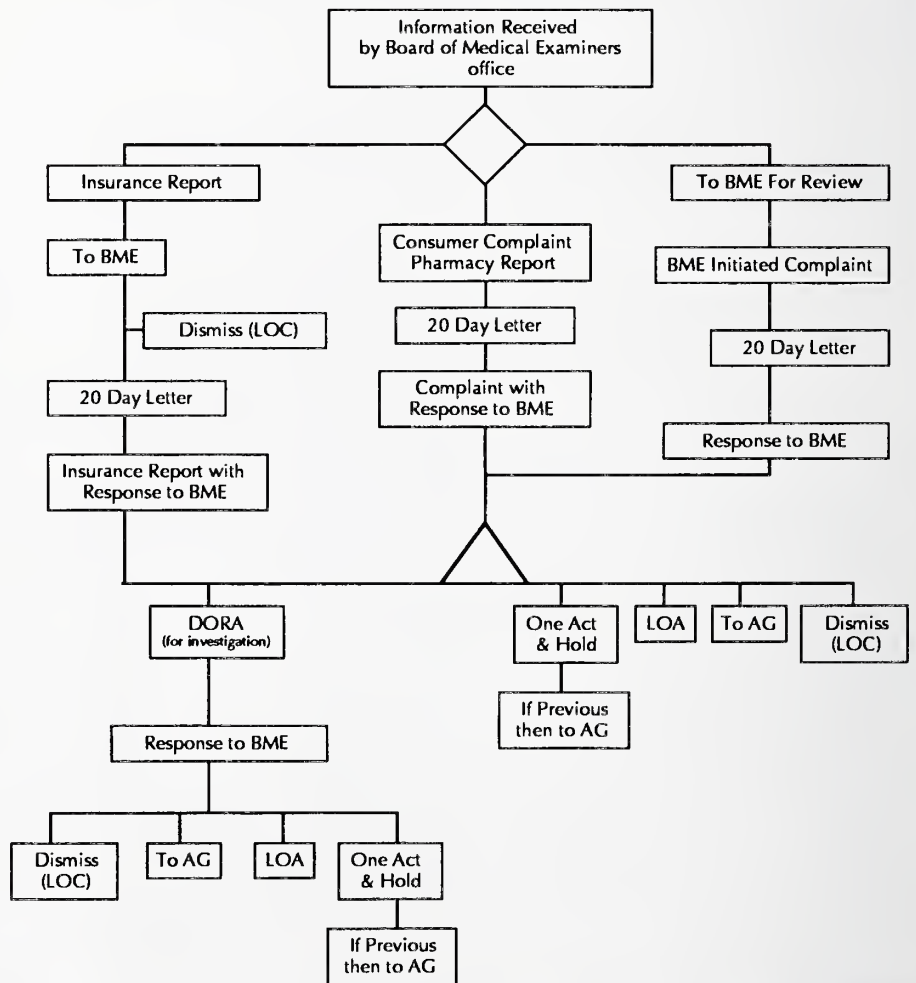
Very truly yours,

FOR THE BOARD OF MEDICAL EXAMINERS

Janice J. Ugale, MD, President

## Procedures of the Colorado Board of Medical Examiners

*Provided for your information by the staff of Colorado Medicine*



### Key:

BME=Board of Medical Examiners  
LOC=Letter of Concern  
DORA=Department of Regulatory Agencies  
AG=Attorney General  
LOA=Letter of Admonition





*Sandra L. Maloney  
Executive Director*

Efforts to establish a national health care reform strategy remain a matter of strong debate. CMS, along with other Colorado policy-makers, is tackling sticky issues of access and financing. I believe that physician leadership can forge a better understanding of the need to address three principal issues: 1) quality of care, 2) the assessment of technology, and 3) the streamlining of administrative costs. If we can reach consensus on these topics, perhaps we can avoid wholesale rationing of services or a government takeover of the health care delivery system.

Some states, including Florida, Minnesota and Vermont, have enacted universal access plans, and other states are considering various reform proposals.

In California, the governor, the state insurance commissioner and the California Medical Association each has proposed different health care reform plans. It appears that consensus is a long way off.

Minnesota's "**HealthRight**" program, which was signed last month by the Governor, requires hospitals, physicians and other providers to pay a 2% tax on gross revenues. The tax is estimated to cost Minnesota's 158 hospitals about \$50 million annually. This tax will help subsidize a universal health insurance program for 400,000 poor and uninsured residents. When fully implemented in 1995, annual administrative costs to the state of Minnesota will be approximately \$200 million. The acquisition of new technology that has not been proven cost effective or clinically necessary, will be monitored carefully. Medicare mandatory assign-

ment will be phased in over several years.

Doctor Butler and I have convened nine meetings throughout Colorado to obtain input from CMS members. These meetings have not been well attended; however, good ideas were presented. These ideas clearly indicate that a physician's primary concern is for their patients, not how much physicians will be paid. In late August, we will be convening a special meeting of the Board of Directors to review all the input gathered from membership. The outcome of this two day meeting will be to formulate a policy statement to be considered by the House of Delegates at the 1992 Annual Meeting.

The Colorado Medical Society needs to be prepared to articulate a position, identify allies, lobby vigorously and seek grass-roots support. We may also have to prepare ourselves to make reasonable concessions.

**NOTE:** The CMS-conducted "Health Care Reform" meetings conclude with the final session to be held Sunday afternoon, July 12, immediately following the Leadership Conference.

Western Slope physicians are urged to attend. For more information, call 1-800-654-5653 and ask for Sandi Maloney's office..

## *Universal Access*

# The All-Payer Alternative: Controlling Costs Through Competition

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*"For the first time, insurers would know what other insurers would pay..."*

Some lawmakers, it seems, have already made up their minds. Many in Congress think a system of mandatory and binding rates for physician services is the best way to control rapidly rising health care costs. As a result, proposals to mandate so-called "all-payer" rates are now part of larger health care reform bills in both the House and Senate.

The cost controls of an all-payer system would prove costly for health care providers. One version of all-payer legislation would force physicians and hospitals to accept Medicare rates from the private sector, a move that in some cases would cut physician's incomes in half, according to the AMA.

But all-payer rates pose an even greater threat to our entire health care system. Under an all-payer system, quality of care would decline because physicians would have no incentive to improve their skills or service. Without hope of reasonable financial rewards for training and experience, many physicians would leave the practice of medicine. Others would be forced out if all-payer rates did not meet their costs in terms of overhead and practice setting. Fewer physicians means areas that already have trouble attracting health care providers would face even greater difficulties. In short, an all-payer system would create more problems than it solved.

Protesting that all-payer rates would be a disaster is not enough to keep them from being enacted. The more constructive approach is to offer an alternative that meets the legitimate cost concerns of all-payer proponents, while maintaining a physician's right to contract freely with the patients to provide services at a mutually agreed upon price. A new proposal from the American Society of Internal Medicine (ASIM) does just that.

ASIM's all-payer alternative would create a competitive market for both physician services and health insurance. The proposal is based on fundamental economic principles and is predicated on the belief that true market forces are more effective than regulation in controlling costs.

Under ASIM's plan, all-payers — public and private — and physicians would be required to use a uniform method — the resource-based relative value scale (RBRVS) — to set their own payment and charge schedules. In calling for use of the RBRVS, ASIM is not advocating an extension of Medicare to the private sector. True, the RBRVS methodology would be adopted, but without the controversial add-ons such as limiting charges or geographic adjustments.

With the RBRVS in place, each private insurer would establish its own single conversion factor on an annual basis. The conversion factor, when multiplied by the RBRVS, would create the maximum charge schedule for each plan that the insurer offers to purchasers. Likewise, each physician would also set a single conversion factor on an annual basis that, when multiplied by the RBRVS would create the maximum charge schedule for all services rendered by the physician.

To create true competition, which would in turn control costs, full disclosure of the conversion factors of all insurers and physicians would be mandatory. For the first time, insurers would know what other insurers would pay, physicians would know what other physicians charge, and consumers



would have all of the information they need to make cost-conscious choices about their health care insurer and provider (for example, to create a simple means of comparing physician charges, all of the conversion factors for physicians in a particular community could be listed in a directory published by insurers).

By comparing the conversion factor of their insurer against that of their chosen physician, patients would be able to determine their percentage of out-of-pocket costs in advance of any given procedure. As an example, assume an individual covered by an insurance plan with a \$35 dollar conversion factor chooses a physician with a \$40 conversion factor. The individual knows in advance of any covered procedure that his or her out-of-pocket costs will be limited to a maximum of 14 percent of the total bill (14 being the percentage difference between 35 and 40).

As a result, patients would be spared the sticker shock they now experience when they get a bill they think is too high and a reimbursement they think is too low.

By setting their own conversion factor, physicians still would be setting their own charges. But those with higher conversion factors would have to prove their worth, or face the prospect of losing patients to a neighboring physician who could provide the same or better level of service for a lower price. Similarly, competitive pressures would force insurers to offer better deals to employers and other purchasers in terms of premium cost, out-of-pocket expenses and availability of services. The bottom line is that the marketplace would drive payments and charges for physician services to the lowest rate that meets the needs of the purchasers in each community.

Low-income patients and individuals with no choice of physician (those needing true emergency care, for example) would be protected under ASIM's plan by balance billing limits.

As for any public insurance plan that may emerge from the current national health care debate, the conversion factor and geographic adjustments for that plan would be established through negotiations between the government and the medical profession, under the auspices of an independent board. Costs for the public plan would be kept in line by negotiating expenditure goals (not caps).

With the nation's health bill expected to double by decade's end, the need to control costs will undoubtedly take on a new urgency. An editorial in a recent *Journal of the American Medical Association* predicted that within the next five years Congress will take drastic action, perhaps even nationalize the entire health care system, if costs continue to rise at an unsustainable rate.

If we are to preserve the current multiple-payer system, we must show policymakers that the system can be retooled to work with greater efficiency. We must come to the table with proposals, like ASIM's, that promote cost-control through competition rather than by coercion. It is not too late to head off all-payer legislation and other heavy-handed regulatory remedies, but the time to promote a workable alternative is now.

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*"...those with higher conversion factors would have to prove their worth."*



# Wait! What Is It We're Trying To Reform?

*"...we must develop consensus of what the root problems are;"*

The Colorado Health Policy Council was asked by Governor Romer to evaluate "ColoradoCare." This concept represents a possible starting point in building a comprehensive health care system for Colorado, but as a stand-alone concept it will not provide comprehensive reform. Many problems are not addressed in "ColoradoCare."

Many governmental entities and other organizations have invested a great deal of time and resources attempting to address comprehensive health care reform. We should draw on their experience.

The "crisis in health care" is perceived primarily as a "cost problem." Concern is expressed that 13% of GNP is going to "health care," but (1) little effort is being expended in defining why costs are at that level and climbing and, (2) no effort is going into defining the proper percentage of GNP that should be assigned to health care. If comprehensive reform is to be undertaken, these two basic problems must be addressed. To answer these two areas will interject complexities into the deliberations.

If comprehensive health care reform is to be accomplished, we must (1) develop consensus of what the root problems are, (2) determine how we will attack the root problems, (3) develop a timetable to accomplish reform, and (4) accurately evaluate the cost of a new comprehensive health care system.

The United Nations defines health as a *"state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."* This definition takes into consideration the parameters that must be addressed if we are to truly reform the health care system.

In addressing the two major problems stated above, we must address a series of wide-ranging issues that have/will impact the health of our state. These include:

- Lack of a long-term planning process
- Cost/income shifting due to underfunded Federal and State programs.
- Erosion of other "social programs" leaving health care as the last safety net for many people.
- Drug abuse, alcoholism, smoking and other self-destructive behavior.
- Air, water, solid waste, toxic and radioactive contamination in our environment.
- A weak economy/unemployment/underemployment.
- Nutrition/malnutrition
- Housing/homeless
- Transportation barriers in accessing care
- Prioritizing of health care





John F. Farrington, MD  
Boulder, Colorado

- Public education as it affects health and access to health care
- Medical education as it affects maldistribution and preventive services
- Capitalization/recapitalization of health care facilities/return on facility investment
- Insurance and government administrative costs overload
- Excess capacity/maldistribution/allocation of health care resources
- Tort system/defensive medicine
- Conflicting federal and state laws, regulations and goals
- Standard basic benefit package
- Employment-based insurance
- Federal/State mandated benefits/programs
- Implementation of new technology
- Pharmaceutical pricing
- Outmoded reimbursement system

*"We must look for innovative new ways of providing and financing health care..."*

If comprehensive reform is to be undertaken, it must be comprehensive. We must look for innovative new ways of providing and financing health care, protecting the health of all citizens, and preventing disease.

In the deliberations of the Colorado Health Policy Council and in addressing the concerns of the elected leaders of Colorado, we can leave no doubt that all issues affecting health must, over time, be addressed. The most important consideration is that we make a start, and that we can build a truly "comprehensive" health care program from this point.

**Ed. Note:** John Farrington, MD, is past president of the American Society of Internal Medicine, past president of Colorado Medical Society, and currently serves as vice-chairman of the Colorado Health Policy Council. A major thrust in Dr. Farrington's presidency of Colorado Medical Society was to cause the Colorado Governor's office to develop a long-term state health care strategy. Dr. Farrington noted in his appeal to Governor Roy Romer (*Colorado Medicine*, Vol 87, No. 7; 1990:176-189) that members of the Society "are anxious to be of help ... in such planning, and eagerly await your response and direction."

# Mini-Internships: A Vital Role

Mini-Internships continue to fulfill a vital role in patient and public health education. The latest, sponsored by the Clear Creek Valley Medical Society, was held April 27-30, 1992.



John Hall (rt) shown observing Dr. Lugene Dorr during carpal tunnel procedure.

Dr. Dorr (l) talking with patient about arm and shoulder movement during examination. John Hall (r) said he was very impressed with Dr. Dorr's patient relationship and relaxing manner ("more like talking with friends than with patients").



Photos by Gil Maestas II  
Colorado Medicine

## Clear Creek Valley Medical Society Spring '92 Mini-Internship

**Bill Lindsey, Intern**  
Benefit Mgmt. & Design, Inc.  
Faculty: Darnell Martin, M.D.

**Rene Hawthorne Shriver, Intern**  
Clear Creek Valley Med. Society  
Faculty: Charles Gartner, M.D.

**Todd Skoda, Intern**  
Sierra  
Faculty: Thomas Golbert, M.D.

**Tom Brown, Intern**  
The Alliance  
Faculty: Malcolm Tarkanian, M.D.

**Jane Berg, Intern**  
Jefferson County Dept. of  
Health & Environment  
Faculty: John Vacanti, M.D.

**Mark Holland, Intern**  
Sierra  
Faculty: Jeffrey Sabin, M. D.

**Judy McCreary, Intern**  
Sierra  
Faculty: Harold Yocum, M.D.

**Lisa Gomez, Intern**  
MCI  
Faculty: Nicholas Besch Jr., M.D.

**John Hall, Intern**  
United (Norwest) Banks  
Faculty: Lugene A. Dorr, M.D.

**Jodi Bratton, Intern**  
Sierra  
Faculty: Wayne Conner, M.D.



# "Ambassadors of Medicine"



by Gil Maestas, II  
for Colorado Medicine

On April 27-30, The Colorado Medical Society and the Clear Creek Valley Medical Society conducted the "Spring Mini-Internship Program." This program has been developed to educate healthcare policy makers, community leaders, and decision makers about the practice of medicine. The "intern" is allowed to follow one or more physicians during a two-day period and have a first hand view of how medicine is practiced on a day-to-day basis.

After completing the program, many participants have expressed a new understanding of the inner-workings of medical practice.

As one past participant stated "I would say that in the 20 patients I saw, the issue which stood out in my mind was that what doctors want to do is just practice medicine. They want to be a doctor, they don't want to be a bookkeeper. They don't want to have to be a financial analyst; they don't want to have to shoot craps on who they fix and who they don't. They just want to serve people. And where they're frustrated is in society's desire to give quality health care to everybody."

The Mini-Internship Program continues to develop friendships and "Ambassadors for Medicine."

The Clear Creek Valley session included business leaders from MCI, Norwest Bank, Sierra, Jefferson

County Dept. of Health & Environment, The Alliance, Benefit Mgmt. and Design, Inc. and Clear Creek Valley Medical Society. Dr. Eugene Dorr and John Hall, Vice President of Norwest Bank Denver allowed **Colorado Medicine** to follow and photograph their day's events. The morning of April 30th was spent in Dr. Dorr's offices examining patients with various orthopedic ailments. Mr. Hall commented that when a physician spends so much time dealing with the business aspects of medicine it is easy for a doctor to forget the human element. He added that Dr. Dorr's rapport with and concern for his patients was refreshing, to say the least. The afternoon was spent at Saint Anthony Central. Mr. Hall observed Dr. Dorr perform carpal tunnel surgery. He stated that he would highly recommend the "Mini-Internship Program" to his colleagues. He said the program allows an opportunity to observe medicine from an entirely new perspective.

After the day's experience, "interns" were invited to a debriefing dinner hosted by Colorado Medical Society. Interns are encouraged to speak openly and frankly about their "day with a doctor." The purpose of the debriefing is to compare preconceptions with actual experiences while encouraging positive as well as negative responses. As expected, this program was a success.

*"...they don't want to have to shoot craps on who they fix and who they dont."*

# Autonomous Medical Treatment Decisions

by Karen B. Best, esq., an Associate with Montgomery Little Young Campbell & McGrew, PC

*Note: This is not legal advice, but is for general information only. For help with specific problems, readers should consult an attorney.*

On June 4, 1992, Governor Roy Romer signed into law Senate Bill 92-3, *Concerning Patient Autonomy in Regard to the Making of Medical Treatment Decisions*. (CMS worked hard on this legislation, influencing its final form.) The legislation is based upon the premises that adults have a fundamental right to make their own medical treatment decision, including decisions regarding medical treatment and artificial nourishment and hydration, and that a patient's lack of decisional capacity to provide informed consent to or refusal of medical treatment should not preclude those decisions from being made on behalf of a person who lacks decisional capacity and who has no known advance medical directive, or whose wishes are not otherwise known.

The Colorado Patient Autonomy Act (CRS 15-14-503, et seq.) recognizes the right of each adult to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event that the patient later is unable to consent to or reject medical treatment, including the right to make medical treatment decisions through an appointed agent by means of a Medical Durable Power of Attorney (MDPA). Other portions of the legislation provide for the selection of a proxy decision-maker when there is no MDPA or other designation of an alternate decision-maker. (CRS 15-18.5-101, et seq.) Article 18.5 attempts to remedy the uncertainty when a patient, who is no longer able to make decisions about his own care, has not ap-

pointed another to act on his or her behalf or has not made his wishes known. The final portion deals with cardiopulmonary resuscitation directives. (CRS 15-18.6-101, et seq.)

## Medical Durable Power of Attorney

**What is a medical durable power of attorney?** An MDPA signed by an adult (18 years or older) specifies an agent to act on behalf of the principal (patient) when the principal lacks the ability to provide informed consent to or refusal of medical treatment. An MDPA may also include any terms, directive, condition or limitation upon an agent's authority, by which the agent must abide. If the agent knows the principal's wishes he must act in conformance with them. If the MDPA contains no guiding terms, directive, condition or limitation, and the principal's wishes are not otherwise known, the agent must determine what is in the best interests of the principal and act accordingly.

**What triggers the involvement of an agent?** "Decisional incapacity" of the principal, which is defined as the inability to provide informed consent to or refusal of medical treatment.

What can the agent do? Generally, but subject to the terms of the MDPA, the agent's authority extends to the following: (1) Provide informed consent to or refuse "medical treatment" on behalf of a principal who lacks decisional capacity; (2) Make any medical treatment decisions the principal could have made;





# Medical Treatment Decisions:

*The attending physician determines that the patient lacks decisional capacity and selects one interested person to serve as proxy decision-maker.*

AMD. Providers and facilities complying with a medical treatment decision of an agent acting in accordance with an AMD, are immune from civil and criminal liability and regulatory sanction.

**Effective date:** Applies to MDPA's executed on or after July 1, 1992.

## **Proxy Decision-Makers**

***Who now has the authority to make medical treatment decisions?***

(1) The patient, so long as the patient has the capacity to provide informed consent to or refusal of medical treatment. However, if the patient lacks the decisional capacity to provide informed consent to or refusal of medical treatment, then (2) an agent designated by the patient in a MDPA, executed pursuant to 15-14-506 of the Colorado Revised Statutes, on or after July 1, 1992, (3) a guardian with medical decision-making authority to provide consent or refusal on the patient's behalf, (4) another known person with legal authority to provide consent or refusal on the patient's behalf, and (5) a proxy decision-maker for medical treatment.

***Who can decide whether the patient lacks decisional capacity to provide informed consent to or refusal of medical treatment?*** (1) A Court or (2) the attending physician. The determination that the patient lacks decisional capacity must be documented in the patient's medical record, along with findings regarding the cause, nature and projected duration of the patient's lack of decisional capacity.

***Who can be a proxy decision-***

***maker?*** Almost anyone who has an interest in the patient. "Interested persons" include the patient's spouse, either parent of the patient, any adult child, sibling, or grandchild of the patient, or any close friend of the patient.

***How is a proxy decision-maker selected?*** The attending physician or his/her designee must locate and inform one ("an") interested person that the patient lacks decisional capacity and that a proxy decision-maker should be selected for the patient. The interested persons must try to reach a consensus as to whom among them will make medical treatment decisions on behalf of the patient. The person selected should be a person who has a close relationship to the patient and is most likely to know the patient's wishes regarding medical treatment decisions. If they cannot agree on who should be the proxy decision-maker or if anyone disagrees with the selection or a decision of the proxy decision-maker, then any "interested person" can seek guardianship of the patient through the Court.

***Does the patient have any say in the determination of his/her decisional capacity or the selection of a proxy?*** Yes. The attending physician or another health care provider must make reasonable efforts to tell the patient about (1) the determination that the patient lacks decisional capacity, (2) the identity of the proxy decision-maker, and (3) the patient's right to object pursuant to section 15-14-506 (4) (a). Under section 506 (4) (a) the patient retains the right to revoke an agent's authority, or the agent's right to consent to or refuse



# Who makes them when the patient can't?

any proposed medical treatment, and no agent may consent to or refuse medical treatment for a patient over the patient's objection.

***Can the proxy decision-maker decide to withhold or withdraw artificial nourishment or hydration?***

Only if the following conditions exist: (1) The attending physician and a second independent physician trained in neurology or neurosurgery certify in the patient's medical record that (2) the provision or continuation of artificial nourishment or hydration is merely prolonging the act of dying and (3) is unlikely to result in the restoration of the patient to independent neurological functioning. The facility's medical ethics committee may be called upon when the proxy is considering or has made a decision to withdraw or withhold medical treatment.

***How can a patient regain decisional capacity?*** If an interested person, the attending physician or the guardian believes the patient has regained the capacity to make medical decisions, the attending physician must reexamine the patient and determine whether or not the patient has regained decisional capacity. The attending physician then enters the determination and the basis for the determination on the patient's medical record and notifies the patient, the proxy decision-maker and the person initiating the redetermination of decisional capacity.

***Immunities:*** Providers and facilities making reasonable attempts to locate and communicate with a proxy decision-maker are immune from civil and criminal liability and regulatory sanction.

## **Directive Relating to Cardiopulmonary Resuscitation (CPR)**

***What is a CPR Directive?*** It's an AMD pertaining to the administration of CPR. By January 1, 1993, the State Board of Health will formulate rules and protocols for implementation of CPR Directives by Emergency Medical Service Personnel (EMSP).

***Who can sign a CPR Directive?*** (1) Any adult (over 18) with decisional capacity; (2) any other person authorized to make medical treatment decisions on behalf of an adult lacking decisional capacity.

***What happens to the CPR Directive upon inpatient admission?*** It is implemented as a physician's order concerning resuscitation as directed by the person in the CPR Directive, pending further physicians' orders.

***Revocation of CPR Directive:*** It may be revoked at any time by the patient, the patient's agent or the proxy decision-maker.

***Presumed consent:*** In the absence of a CPR Directive, a person's consent to CPR must be presumed.

***Immunities:*** Health care providers, EMSP, and health care facilities must comply with any "apparent and immediately available" CPR Directive, and are immune from civil and criminal liability and regulatory sanction for their compliance.

To ensure conformance with statutory requirements for a Living Will, Advanced Medical Directive, Medical Durable Power of Attorney, or CPR Directive, consult an attorney.

*"To ensure conformance with statutory requirements for a Living Will, Advanced Medical Directive, Medical Durable Power of Attorney, or CPR Directive, consult an attorney."*



Edie K. Register, Director  
Health Care Financing Department

*"In the future Medicare will be denying and not just notifying."*

## Medicare Denies 37,340 Claims

This could have been the headline if the Health Care Financing Administration (HCFA) had instructed the Medicare Carrier to start denying claims that do not contain appropriate 4 and/or 5 digit diagnosis codes.

A recent report from Medicare indicated that in a one month period 37,340 claims would have been denied for the above reason. This figure represents 18.3 % of the claims processed for one month. The Carrier has published numerous bulletins containing information about ICD-9-CM diagnosis codes. The latest bulletin was dated February 14, 1992.

In the future Medicare will be denying and not just notifying physicians of an invalid diagnosis code. Please review the February bulletin and make your billing staff aware of this problem.

Please contact Edie Register or Debra Jones at the Colorado Medical Society with any questions. You may also contact Blue Cross Blue Shield of Colorado, the Medicare Carrier.

## Pilot project for telephone reviews

Blue Cross and Blue Shield of Colorado (BCBSC) announces they are participating in a Health Care Financing Administration (HCFA) study which could be of significant value to Colorado providers.

Effective May 15, 1992 you can call the Medicare Appeals staff to request a review of a Medicare claim. The review will be conducted while you are on the telephone. At

the close of the telephone conversation you will be notified of the review decision and will subsequently receive a written decision. The telephone review process **eliminates** the requirement for you to **file a written review request** and **wait** for their response.

To qualify for a telephone review you must be a **participating** Medicare provider and/or must have submitted an **assigned electronic** claim. The date of service must be on or after January 1, 1992.

Certain services are excluded from the telephone review study. Excluded services are:

- \*oncology
- \*waiver of liability issues
- \*co- and team surgery
- \*durable medical equipment (DME)

To request a review of a claim by telephone simply call (303) 831-3287 during the following hours:

- \*9:00 AM until 11:00 AM
- \*1:00 PM until 3:00 PM

A member of the Medicare Appeals staff will be available to assist you Monday through Friday.

When you call please have **all** information available, including any additional information, you want considered. Telephone reviews requested for multiple claims may be limited due to call demand and availability of staff.

Your comments are very important to the success of this study. BCBSC has agreed to conduct this study for one year unless the project proves unsuccessful.

\*Please limit your calls to telephone review requests only. All other requests for information should continue to be directed to Medicare





Provider Telephone service representatives at (303) 831-1221.

## Prescription for Durable Medical Equipment

by Grant Steffen, MD

Medical Director, Medicare Part B  
Blue Cross/Blue Shield of Colorado

Most physicians do a good job when writing prescriptions for drugs because drug therapy is a big part of their training. However, the same is not always true for prescriptions written for durable medical equipment (DME). Physicians get minimal training in prescribing wheelchairs, home O<sub>2</sub>, prostheses, orthotics, TENS units and the like. The result of this lack of training is, many DME prescriptions that are either justified but filled out incorrectly or unjustified.

An example is home O<sub>2</sub>. The prescription or certification will almost never be approved unless it contains the results of blood gases done with the patient at rest *and on room air*, yet the most frequent reason for the reviewers to refer these certificates to me is because they fail to include that information. If you have strong reasons that prevent your supplying that information, you must state those reasons on the certificate.

I have seen prescriptions for TENS units where the physician didn't state where on the body that unit was to be applied. Physicians have ordered motorized wheelchairs when the patient didn't even need a regular wheel chair (the patient was ambulatory). For the patient with a BK amputation, the prescription will often read, "prosthesis, BK amputation." This unrestrictive prescription gives the supplier license to provide

many attachments that have marginal value, if any.

Another example is durable medical equipment prescribed for the nursing home patient. This is often done without the attending physician's evaluation. Recently a self-employed occupational therapist came to a nursing home and asked to be allowed to evaluate all the patients concerning need for physical restraints. The nurse got phone orders for this evaluation from the attending physicians who also approved via phone orders the orthotics recommended by the O.T. The problem was that she furnished wheel chair pads, not orthotics (something applied directly to the body), these pads were not medically necessary and they cost Medicare (the taxpayer) \$1,000 per set. Take comfort in knowing that the Inspector General's office is investigating. Do not approve *any* durable medical equipment unless you bring to that approval the same knowledge that you bring to approving — prescribing — a drug. If you don't have the knowledge necessary to prescribe such equipment, please consider getting a consultation from an orthopedist, physiatrist, or neurologist. These specialists will usually have the required knowledge.

I make this strong recommendation because it makes for better medical care and it avoids the unnecessary purchase of very costly equipment. The government estimates that for durable medical equipment alone, it pays for unnecessary or fraudulent prescriptions, over *one million dollars per day*. So please take time with that prescription and refer when necessary.

*The Government pays a million dollars per day for unnecessary or fraudulent prescriptions.*



A monthly report of current and on-going activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.

July, 1992

At recent meetings the **COUNCIL ON COMMUNITY HEALTH ISSUES** has chosen the following public health concerns as the most important for the Colorado Medical Society to address:

- (1) Wellness Care
- (2) Reproductive Health
- (3) Domestic Violence
- (4) Care of HIV + patients
- (5) Environmental Health
- (6) Immunizations

It was decided that the following committee structure will be used to address these issues:

- (1) Environmental Health
- (2) HIV Committee (to replace the AIDS Task Force)
- (3) Environmental Health
- (4) Family Health and Safety

(this committee will include the former Maternal and Child Health and Seniors Health Issues Committees and will broaden its scope to include reproductive health and injury prevention. Wellness care will be addressed in each of the committees as it relates to the focus of the committee.

Access to care and the financing of medical care were also determined to be high priority issues for the Society; these are being addressed by other Councils and Committees.

Dr. William Miller, chair of the former **MATERNAL AND CHILD HEALTH COMMITTEE** has agreed to co-chair the new **FAMILY HEALTH AND SAFETY COMMITTEE**. A co-chair is being sought to assist him. If you are interested, please contact Ellen Stein or Marilyn Barton at CMS.

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## AMA moves to take over CME accreditation

The AMA says CME program quality has been too loosely monitored to fit with its increasingly important role in assuring high professional standards. But the Accreditation Council for Continuing Medical Education (ACCME), which now relies on complaints and reaccreditation to control quality, notes it already is moving to improve monitoring.

The ACCME is the main quality assurance body for CME programs nationwide. It accredits about 500 CME sponsors, including medical schools, medical and specialty societies, hospitals and the health care industry.

Concerns over monitoring CME quality have been heightened of late by reports of abuses in industry-funded CME programs. The Food and Drug Administration has made it clear it wants the line between education and promotion carefully drawn and heeded.

In March, the council approved a random-monitoring system for CME programs, to be phased in over several years.

The AMA is proposing to take over operation of the ACCME. AMA Executive Vice President **James S. Todd, MD**, wrote in a March 10 letter outlining the proposal, saying that "We have an immature mechanism to monitor and enforce our standards." Todd went on to say that "Continuing Medical Education is a key frontier of medicine today."

Currently, the Council of Medical Specialty Societies (CMSS) has the contract to administer the ACCME. The Council has held the con-

tract for the past ten years, and its agreement runs through December 1993. The CMSS says it won't relinquish the contract unless the five other ACCME parents want it to do so. They are the American Board of Medical Specialties, American Hospital Association, Association of American Medical Colleges, Federation of State Medical Boards and the Association for Hospital Medical Education.

If awarded the contract to run the ACCME, the AMA would give the accreditator a half-million dollars, free office space at the AMA building and use of AMA officials over the first two years. The AMA would also help found a CME institute, which would undertake detailed long-range planning to anticipate the kind of CME courses physicians would need.

**M. Roy Schwarz, MD**, AMA's senior vice president for medical education and science, said "We see a need and we're willing to help meet it. It's not an ultimatum, it's an offer." Schwarz said better planned CME would help contribute to quality assurance. Schwarz is former Dean of the University of Colorado School of Medicine.

## BME Rules & Regs for Athletic Trainers and Physician Assistants

The Colorado Board of Medical Examiners issued rules and regulations concerning athletic trainers, effective May 30, 1992. The rules specify types of services which can be offered by a trainer who is duly accredited by authorized national athletic training standards accreditation organizations.

The BME also announces a rulemaking hearing concerning certification of and practice by Physician Assistants (PAs). The hearing will be held on Thursday, July 16, 1992, at 1:30 p.m. in the Radisson Hotel, 1550 Court Place, Denver. The purpose of the rules is to clarify the form in which a physician assistant may issue a prescription medication order. The rules were first promulgated in 1953, and the new rulemaking is to reflect the evolution in clinical practice that has taken place during this 39 year period.

If the reader wishes to receive printed copies of either of these notices, please contact the Colorado Medical Society at (303) 779-5455 or 1-800-654-5653 (toll-free number outside the Denver calling area).

## Copic's Thrower Elected Secretary-Treasurer of PIAA

Larry W. Thrower, President and Chief Operating Officer of Copic Insurance Company, has been elected Secretary-Treasurer of the Board of Trustees of **Physician Insurers Association of America**. He has been a member of the PIAA Board since 1990.

The association consists of 44 physician-owned medical professional liability insurance companies which collectively provide malpractice insurance for nearly two-thirds of all practicing physicians in the U.S.



### **Kathy Gardner, BSN, MA, Elected to Spalding Board**     **Sterling Physician Runs For CU Regent Post**



*Kathy Gardner, BSN, MA,*

Kathy Gardner, BSN, MA, Risk Manager of Copic Insurance Company, has been elected to the Board of Directors of Spalding Rehabilitation Hospital in Denver.

Ms. Gardner, a member of the Copic staff since 1986, previously served 8 years as Head Nurse, and one year as Director, Education/Non-Clinical Services of Swedish Medical Center in Englewood, CO. Prior to that she worked as staff nurse, charge nurse and supervisor in hospital settings in Hawaii, South Carolina and in Denver.

Ms. Gardner is a graduate of the St. Louis Hospital School of Nursing where she received her R.N. in 1965, the University of South Carolina with a B.S.N. in 1976, and her M.A. from Webster University in Webster Grove, Missouri in 1983.

Elected to the Spalding Board with Ms. Gardner were Elena Draznin, M.D., Medical Director of Spalding Hospital South, Pasquale Marranzino Jr., President of Karsh & Hagan Advertising, and W. Peterson Nelson, President of Nelson, Benson & Zellmer, Inc.



*John E. Elliff, MD*

John E. Elliff, MD, a Sterling, Colorado Ophthalmologist, has announced his candidacy for the position of Regent of the University of Colorado from the Fourth Congressional District.

Elliff, a member of the CMS Board of Directors, is a life-long resident of Eastern Colorado. He is a 1953 graduate of CU, and received his MD in 1956 and MS in Surgery in 1960. He has been a member of the Volunteer Faculty of the University of Colorado Medical School since 1960 and is now an Associate Clinical Professor of Ophthalmology.

Dr. Elliff has also served on the Colorado State Board of Health under two governors.. He has been a Republican County Chairman and as a National Presidential Delegate.

Dr. Elliff said of his candidacy that, if elected, "the presence of a Regent with a medical background will, I believe, be important to the balance of the Board of Regents."

The Colorado Medical Society and Colorado Medical Political Action Committee (COMPAC) have endorsed Elliff's candidacy.

### **Workers' Compensation Level II Physician Accreditation Seminar**

The Division of Workers' Compensation will hold its first Level II Physician Accreditation Seminar on August 21, 1992 at Arapahoe Community College in Littleton. Physicians who render impairment ratings as Independent Medical Examiners or provide impairment evaluation for workers injured on or after July 1, 1991 are required to successfully complete this course by January 1, 1993. Participation is limited to the first 100 registrants.

The Level II Physician Accreditation Seminar is designed to provide physicians with an understanding of the administrative, legal and medical aspects of the workers' compensation system. It will also instruct physicians in the uniform use of the *American Medical Association Guides to the Evaluation of Permanent Impairment, 3rd Edition Revised* in a manner which conforms to the Colorado Statutes.

The Division plans to offer this seminar in Durango, Grand Junction, Greeley and Colorado Springs later this year. For additional information or registration forms, please contact Faye Boyd at 764-4355

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for the 1992  
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# An expensive charting system is one that *doesn't* work.

**Subjective:** "The Plaintiff's husband had his first embolism 21 months ago."

**Objective:** "Doctor, please show the *court* that record in your chart."

**Assessment:** "Oh ... #@\$#@\* ...  
..... I can't find it!"

**Plans:** ... Call BIBBERO!!!



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## RUMINATIONS

(*def: to chew again what has been chewed slightly and swallowed; to REFLECT*)

William S. Pierson  
Managing Editor

### The Art of Medicine

Norman Cousins, Author, at graduation ceremonies, Tulane University, July, 1982.

"Many patients have a growing sense of impersonalization and fragmentation. They go to their doctors' offices seeking refuge from their fears and loneliness and do not adjust easily to new encounters, either with those who preside over separate domains in medical science or with highly sophisticated marvels of diagnostic technology. The conclusion is clear: doctors who spend more time with their patients may have to spend less money on malpractice insurance policies."

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# An Open Letter to Colorado Physicians



**BELLE BONFILS  
MEMORIAL BLOOD CENTER**

---

Since 1976, the nation, as well as all of the blood centers in Colorado, have been on a Volunteer Donor Program. This means that blood donors are recruited and blood obtained only as an altruistic gift. This has increased the safety of the nation's blood supply significantly. Additionally, with the devastation of the AIDS epidemic, blood centers seek donors with no recognizable high risk activity such as IV drug abuse, sexual promiscuity, male homosexuality, etc.

With these tenets in mind, it appears to us that there is an increase in the activity of some physicians to encourage their patients to become blood donors in order to have their HIV status obtained free of charge. In view of the above blood donor philosophy, this activity is totally inappropriate. First of all, these people are not "volunteer" blood donors, and secondly, if they need to know their HIV status, they more likely have some kind of high risk behavior that concerns them. I would simply ask if you would want a unit of blood from such a donor to be given to one of your other patients or would you rather have it come from a potentially safer donor?

I would appeal to all physicians in the State to refrain from suggesting blood donation as a way of getting HIV tests. There are alternate test sites available through the State Health Department and all commercial labs offer HIV testing at nominal charges.

Sincerely,

W. C. Dickey, M.D.  
CEO/Medical Director  
Belle Bonfils Memorial Blood Center  
Denver, Colorado



# PARTICIPATE IN 1992 !

Your "Participation '92" Chairmen want to know if you are working in a campaign - we urge you to write the CMS Government Relations Office, PO Box 17550, Denver 80217-0550 or call the office at 779-5455 or 1-800-654-5653.

**Colorado's Primary Election is August 11.** Don't take the chance that you may be detained in your office and not make it to the polls. Vote by Absentee Ballot. You may obtain an absentee ballot by calling your County Election Commission or, in the smaller counties, your County Clerk of Courts by August 7th!

## Redistricting

State House and Senate district lines are drawn by the 11-member Colorado Reapportionment Commission. The Commission comes into existence once every 10 years, after each federal census, pursuant to an initiated amendment to the Colorado Constitution approved by the voters in 1974.

The State constitution, federal law, and court cases impose a long list of requirements for reapportionment plans.

**(1) Equal population.** Each district must have population "as nearly equal as may be", and the total deviation from the smallest district to the largest cannot exceed 5%.

**(2) Preservation of minority voting strength.** Under the federal Voting Rights Act, a reapportionment plan must not interfere with the ability of a minority group to elect

representatives of its choice.

**(3) Compactness.** Each district must be "as compact in area as possible," and the aggregate linear distance of all district boundaries must be as short as possible.

**(4) Contiguity.** Districts must consist of contiguous territory; a district cannot include an enclave completely surrounded by another district.

**(5) Preservation of whole counties and municipalities.** Districts should include whole counties except where necessary to meet equal population requirements.

**(6) Preservation of communities of interest.** Communities of interest, including ethnic, cultural, economic, trade area, geographic, and demographic factors, shall be preserved within a single district whenever possible.

## Major Changes in State Senate Districts

**District 4:** This seat is currently held by **Harold McCormick (R)**, Canon City. The district has been greatly expanded. Senator McCormick has represented Custer County and a portion of Pueblo county as well as Fremont, Lake, and Park. Custer & Pueblo counties now fall in Senate District 5 which is represented by Senator **Bob Pastore (D), Monte Vista**. The counties of Chaffee, Delta, Gunnison, Hinsdale, and Pitkin have been added to Senator McCormick's district. Not only does this substantially increase the geographic area of the district - the voter profiles change dramatically with the addition of Delta,

Gunnison and Pitkin counties. As you know, Aspen is located in Pitkin county and that population alone could greatly impact an election. **Richard Hamilton (D), Fairplay and Linda Powers (D), Crested Butte** will compete in the Democrat primary to determine who will face McCormick in the general election.

**Senators Sam Cassidy (D), Pagosa Springs; Bob Pastore (D), Monte Vista, and Jim Rizzuto (D), La Junta,** will represent the entire southern portion of Colorado. Senator Cassidy's district did not change and he will continue to represent the counties of Archuleta, southern Delta, Dolores, La Plata, Montezuma, Montrose, Ouray, San Juan and San Miguel. Senator Pastore lost the counties of Chaffee, Delta, Gunnison and Hinsdale to Senator McCormick. The counties of Custer, Huerfano, Las Animas and a portion of Pueblo have been added to Senator Pastore's District 5. Previously, Senator Rizzuto represented Huerfano and Las Animas Counties. His district was increased with the addition of the southern portion of El Paso County, and the counties of Kit Carson and Lincoln. Senator Don Ament (R), Iliff, represented Kit Carson County in the past; Senator Ray Powers (R), Colorado Springs, serves as the representative to Kit Carson County.

## Breakdown of El Paso County Senatorial Districts:

District 9 (northern El Paso): Mike Bird (R)

District 10 (east and southeast Colorado Springs): Ray Powers (R)





**Ben Galloway, MD**  
Chairman,  
CMS Participation '92



**Patti Brown**  
CMS Auxiliary Legislative Affairs  
Chairman 1991-1992  
Co-Chairman CMSA Participation '92

District 11 (central and south Colorado Springs): Jeff Wells  
District 12 (southwest El Paso and Teller counties): Mary Anne Tebedo (R).

The terms of Senators Bird and Wells do not expire until 1995; Senators Powers and Tebedo are running unopposed.

**Senator Sally Hopper's District 13** changed only in the ski areas she represents - she lost Pitkin County to Senator McCormick and picked up Eagle County from Senator Wattenberg.

**The growth in Arapahoe County is reflected in the fact that there will be six senators representing this county:** Tom Blickensderfer (R), Englewood; Bill Owens (R), Aurora; Elsie Lacy (R), and Richard Doby (R), Aurora will be vying for the District 28 seat in a primary - this is the seat being vacated by Jack Fenlon (R), Aurora; former state representative, Steve Ruddick (D), Aurora is being challenged by David Rowberry (R), Englewood, and Joseph Daniluk (R), Aurora, for the new District 29 seat; Dick Mutzebaugh (R), Highlands Ranch, has added Elbert county to his district which currently consists of portions of Arapahoe, Douglas, and Jefferson counties, and Senator Dottie Wham will compete with Mike Johnson (D) for a newly-carved Senate District 35 which includes Arapahoe County and Southeast Denver County.

Due to a decrease in population **Denver County lost a senate seat.** Senator Pat Pascoe's current District

34 has been incorporated into Districts 32 and 35. Senator Pascoe does not reside within the parameters of Senate District 35 so she cannot challenge Senator Wham for that seat. She does reside in District 32 but that seat is held by Senator Ray Peterson who is not eligible for re-election until 1994.

### Senate Races

#4: Harold McCormick (R), Canon City vs Richard Hamilton (D), Fairplay, and Linda Powers (D), Crested Butte.  
#8: Dave Wattenberg (R), Walden - Unopposed  
#10: Ray Powers (R), Colorado Springs - Unopposed  
#12: Mary Anne Tebedo (R), Colorado Springs - Unopposed  
#14: Bob Schaffer (R), Ft. Collins - Unopposed  
#17: David Leeds (R), Louisville vs. Paul Wiseman (D), Louisville  
#18: Jana Mendez (D), Boulder - Unopposed  
#19: Al Meiklejohn (R), Arvada vs Evie Hudak (D), Arvada  
#21: Bonnie Allison (R), Edgewater vs Lynn Watwood (R), Lakewood, -Primary race  
#23: Ted Strickland (R), Westminster vs. Lloyd Casey (D)  
#25: Bob Martinez (D), Commerce City vs Thomas F. Todd (R)  
#26: Tom Blickensderfer (R), Englewood vs Lloyd Covens (D), Englewood  
#27: Bill Owens (R), Aurora vs Paul Rosenberg (D), Aurora  
#28: Elsie Lacy (R), Aurora vs. Richard Doby (R), Aurora - primary race  
#29: Steve Ruddick (D), Aurora vs

the winner of the Republican primary between David Rowberry (R), Englewood and Joseph Daniluk (R), Aurora.

#31: Don Mares (D), Denver - unopposed  
#33: Regis Groff (D), Denver vs John Dates (R), Denver  
#35: Dottie Wham (R), Denver, vs Mike Johnson (D), Denver

### House of Representatives

**The population changes can be easily recognized in the changes in seats in the House districts - Denver and the southern portion of the state came up losers while Arapahoe, Boulder, Douglas and El Paso Counties gained in population.**

*Many changes were made in the numbering of House districts so we advise voters to forget their old House district numbers and begin familiarizing themselves with the new numbers. The changes are most noticeable in the counties that are listed above with the major population increases and decreases.*

**House District 3: Redistricting pits two current legislators against each other - Wayne Knox (D), Denver and Chuck Henning (R), Englewood.** Representative Henning currently holds the seat in House District 37 which was vacated by Repr. Tom Blickensderfer when he moved from the House to the Senate upon the resignation of Senator Terry Considine.

**House District 6 (East Central Denver & Glendale): The reapportionment process incorporated**

**District 9 (now held by Pat Grant) and the southwestern portion of District 6 (now held by Jerry Kopel) to form the new District 6. Both Grant and Kopel are retiring from the legislature. Candidates are: Clarke Houston (R), Denver vs the winner of a Democrat Primary between Diana DeGette (D), Denver, and Barbara Elliot (D), Denver.**

**House District 37 - Greenwood Village, Cherry Hills, Englewood:** A portion of District 40 currently represented by Jeanne Adkins (R), Parker, has been woven into District 37 due to the population explosion in Douglas County. Martha Kreutz (R), Littleton and Scott Levin (D), Englewood, are competing for the District 37 seat. **Jeanne Adkins (R), Parker,** will now represent District 65 - Douglas County. **Chuck Henning (R), Englewood,** who replaced Tom Blickensderfer now has District 37, but the loss of population in Denver moves Chuck to House District 3 where he will compete against **Wayne Knox (D), Denver.**

**House District 44 - Custer, Fremont, Pueblo & Teller Counties:** Now a combination of portions of Steve Arveschoug's District 44, and Ken Chlouber's District 61. Candidates are: former legislator Bob Shoemaker (D), Canon City, and Larry Schwartz (R), Wetmore.

**House District 47 - Baca Bent, Crowley, Las Animas, Otero, & Pueblo:** **Repr. Mike Salaz** now represents Huerfano, Las Animas, Otero & a portion of Pueblo counties. Redistricting extends his district to the southeastern border of Colorado. He is being challenged by Dan Hyatt (D), a newspaper publisher from La Junta who was defeated by Brad Young in the 1989 elections.

**House District 61 - Chaffee, Gunnison, Hinsdale, Lake, Park, Pitkin & Teller:** Seat currently held by Ken Chlouber (R), Leadville, - Pitkin and Hinsdale counties have been added. Hinsdale county was included in Lewis Entz' old district and Scott McInnis currently represents Pitkin County.

**House District 63 - Arapahoe, Cheyenne, Elbert, Kiowa, Kit Carson, Lincoln, Prowers & Yuma Counties:** This is the area where reapportionment takes its toll since it incorporates counties currently being represented by two fine legislators - **Bud Moellenberg and Brad Young.** Unfortunately, these two candidates will be pitted against each other in Republican primary.

**House District 64 - Douglas County:** This district is now #40 which includes the Greenwood area of Arapahoe County - Repr. Jeanne Adkins' district is running unopposed for the District 64 slot.

**House District 65 - Logan, Morgan, Phillips, Sedgwick & Washington Counties:** The counties of Phillips and Washington have been added to Bob Eisenach's district. Repr. Eisenach is a Democrat who is being challenged by former state senator Jim Brandon (R), Akron.

#### CANDIDATES BY COMPONENT SOCIETY

##### Arapahoe County Medical Society

Congressional District 6

##### State Senate Candidates:

Senate District 22 - Jefferson County

Senate District 26 - Arapahoe & Jefferson Counties

Senate District 27 - Arapahoe

Senate District 30 - Arapahoe, Douglas, Elbert & Jefferson

##### Democrat

##### Republican

Dan Schaefer, Lakewood

Bill Shroeder -Term Expires in '95  
(Property Acquisition Officer)  
4420 S. Braun Court, Morrison 80465  
(H) 697-8321 (B) 688-3100

Tom Blickensderfer  
9 Parkway Drive , Englewood 80110  
(H) 758-0146 (B) 320-6100

Bill Owens  
15928 E. Mercer Circle, Aurora 80013  
(Assoc. Director)

Dick Mutzebaugh  
9965 S. Wyclife Dr.,  
Highlands Ranch 80126  
(H) 791-4063 (B) 795-4639



# CANDIDATES BY COMPONENT SOCIETY

	Democrat	Republican
Senate District 35 - Arapahoe, Southeast Denver		Dottie Wham 2790 S. High, Denver 80210 (H) 757-0615 (Legislator)
House District 3 - South Denver, Englewood, Sheridan	Wayne Knox 761 South Tejon, Denver 934-8707 (Retired Teacher)	Chuck Henning 2951 S. Franklin, Englewood 80110 781-8754 (Writer/Consultant)
House District 37 - Green- wood Village, Cherry Hills, Englewood		Martha Kreutz (Hank Brown staffer)
		Jim Varner (AT & T Exec)
House District 38 - Little- ton		Phil Pankey 5763 Shasta Circle, Littleton 80123 798-5873 (Business Consultant)
		John Trujillo (Restaurant Owner)
House District 39 - South Arapahoe		Paul Schauer 7255 S. Jackson Court, Littleton 80122 (H) 770-3872 (B) 744-5638 (Gates Public Relations)
<b>Aurora/Adams County</b>		
House District 64 - Dou- glas		Jeanne Adkins 6517 N. Pinewood Dr., Parker 80134 841-8829 (Freelance Journalist)
Sixth Congressional District		Dan Schaefer
Senate Dist. 24 - Adams	Bob Martinez	Thomas F. Todd 6462 E. 63rd Avenue Commerce City 80022 H) 287-8111
Senate Dist. 27 - Arapahoe (Aurora)		Bill Owens 15928 E. Mercer Circle, Aurora 80013 (Association Director)
Senate Dist. 28 - Arapahoe (Aurora)		Elsie Lacy (Aurora Councilwoman)
		Richard Doby (Former Colo. State Banking Comm.)
Senate Dist. 29 - Arapahoe (Aurora)	Steve Ruddick Attorney 1031 Sable Blvd. Aurora 80011 360-0715 or 360-7406	

# **Aurora/Adams County Medical Society (Cont'd.)**

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Northeast Denver

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Denver 80207  
(H) 320-0495 (B) 764-3578  
School Administrator

House Dist. 7

Gloria Tanner  
Rochune Scogins  
Jacqueline Patterson

House Dist. 36

Don Armstrong  
(Labor Representative)

Don Hamstra  
(Brighton Mayor - Health Official)

House Dist. 40 - South  
Aurora

Ron Anderson

Mike Coffman  
PO Box 440740  
Aurora 80044  
(H) 766-0918 (B) 671-6402

House Dist. 41

Peggy Kerns  
1124 S. Oakland Court  
Aurora 80012  
696-7178  
Businesswoman

House Dist. 42 - Aurora

Eugene Hogan  
Teacher

Roy Reger  
11684 Bayaud Drive, Aurora 80012  
343-3331  
(Educator)

House Dist. 43 - Aurora

Debbie Allen

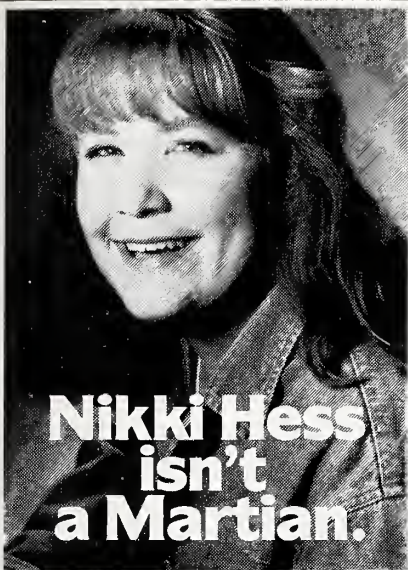
House Dist. 64 - Douglas

Jeanne Adkins  
6517 N. Pinewood Dr., Parker 80134  
841-8829  
(Freeland Journalist)

**Please note:** Repr. Adkins is listed under Aurora/Adams Medical Society because CMS staff believes there are a number of A/A Medical Society members who reside in Parker. If this is not the case, we should remove her name from the listing.

**Participation '92** is a call for your active participation in the political process.  
**COMPAC (Colorado Medical Political Action Committee)** is one avenue of involvement.  
Contact your CMS Government Affairs staff person today and join COMPAC... you can have a decisive part in selection of the candidates you know will be strong medical representatives.  
Call the CMS Government Affairs Office at (303) 779-5455 or  
(outside the Denver calling area) 1-800-654-5653





**Nikki Hess  
isn't  
a Martian.**

But the way some kids treat her, she might as well be from another planet. Just because she has epilepsy.

You know that epilepsy doesn't make her weird. It doesn't affect her abilities, her sense of humor, or her qualities as a friend.

But walls of misunderstanding, overprotection or prejudice still keep kids like Nikki away from other children—and exclude them from sports, trips, and other normal school activities.

Nikki is just like anyone else except for one thing. She has epilepsy. While some of your epilepsy patients need special help, they don't need walls. You can help get rid of the walls around children with epilepsy or other disabilities—and count them in.

Let's help tear down the walls around kids like Nikki. Call the Epilepsy Foundation of America, 1-800-EFA-1000 or the Epilepsy Foundation of Colorado (303) 761-2742.



**Epilepsy Foundation of America**

This space donated by publisher.

# Three good reasons to submit your claims electronically.

Legislation that will move Medicare business to a totally paperless environment is already in the draft stages. So there's no question that electronic processing is the future of claims submission. Fortunately, it's a future we can look forward to. Here's why:

## 1. You can save money.

Faster claims turnaround time can significantly improve cash flow. And that means the interest accrual works in your favor.

## 2. You can save time.

Electronic processing eliminates hours of claims sorting and handling, proofing, mailing, and other time-consuming tasks.

## 3. You can avoid frustration.

Electronically submitted claims are exceptionally accurate, so your resubmittals will be greatly reduced.

# One good reason to do it now.

## FREE Software!

Between now and August 15, the software you need to develop an electronic media claims program is available free.\* So a good idea just got even better.

For more information, talk with a Blue Cross and Blue Shield of Colorado representative at (303) 831-2626. Electronic claims will benefit your practice for many years to come. But this special offer only lasts until August 15.



**Blue Cross  
Blue Shield**  
of Colorado

\*Some restrictions apply.



by *Judy Donaldson, M.S., M.T.*  
Division of Laboratories  
Colorado Department of Health

## CLIA Seminar schedule:

The Colorado Department of Health, Division of Laboratories, is presenting a series of training sessions, "Introduction to CLIA '88." These seminars will provide an overview of the organization and contents of the regulation. Frequently asked questions will be addressed and time lines will be discussed.

Persons who should attend are laboratory directors, managers, consultants and testing personnel (especially in previously unregulated sites), physicians, nurses, assistants and laboratory personnel.

July 23, 7pm, Denver, Marriott, Hampden & I-25

July 29, noon, Colorado Springs, Red Lion, Circle & I-25

July 30, noon, Greeley, Ramkota Inn, 701 8th Ave

August 3, noon, Durango, Red Lion, 501 Camino Del Rio

August 5, noon, Denver Regency, 38th & I-25

August 6, noon, Fort Collins, Holiday Inn, 425 W. Prospect Rd.

August 7, noon, Pueblo, Hotel Pueblo, Hwy 50E & I-25

**Fee:** \$15.00.

**Registration deadline:** Form and payment must be received five working days prior to course.

**For information or registration** packet, call: Judith Donaldson, Coordinator and Trainer (303) 331-4712.

Congress passed the *Clinical Laboratory Improvement Amendments of 1988* (CLIA) to set standards for all laboratory testing which examines human specimens for diagnosis, treatment, prevention or health assessment. On Feb. 28, 1992 the Health Care Financing Administration (HCFA) published the final rules to implement this law effective Sept. 1, 1992.

Laboratory tests are regulated by complexity. Eight visually read tests fall in the waived category: 1) Urinalysis-dipstick, 2) fecal occult blood, 3) ovulation test, 4) urine pregnancy test, 5) erythrocyte sedimentation rate, 6) hemoglobin by copper sulfate, 7) spun hematocrit

and 8) blood glucose-using FDA device cleared for home use. Sites conducting any of these eight tests must apply for a certificate of waiver. These tests are not subject to the rules imposed on all remaining tests that are divided into moderate to high complexity categories.

The rules include specifications for personnel, record management, quality control, proficiency testing, inspection, fees and penalties. **It will be illegal to conduct testing after Sept. 1, 1992 without a certificate of waiver or certificate of registration.** Colorado does not have state laboratory regulations and will not be eligible to apply for a state exemption. Laboratories will be inspected by a HCFA agent, a contracted state agency or an approved professional accreditation organization.

The first step in obtaining a CLIA certificate is to mail an information form (HCFA-109). Based on the information supplied, a bill or "coupon" (HCFA-35A) for certificates of waiver or registration will be mailed. Over 10,000 forms were mailed to Colorado addresses by HCFA. If you have not received or completed the information form you may request one by calling HCFA's Denver office at 844-4726 or the "CLIA Inquiry Hotline" in Baltimore at 410-290-5850. This hotline also has a menu of electronically recorded messages available 24 hours a day about the regulation and forms; it will accept voice-mail messages after business hours.

The following questions take you through the steps you need to check to assure compliance.



# Questions Frequently Asked About CLIA

- Q. Since I only perform a few simple medical tests, do CLIA regulations apply?
- A. Yes. If you perform only the waived tests, you must obtain a certificate of waiver. If you do any other tests, you must comply with the moderate or high complexity requirements. It is estimated that most newly regulated sites will only perform waived and moderate tests. You must have a CLIA certificate by Sept. 1, 1992 to legally conduct testing.
- Q. Must moderate complexity tests be under a director who is a pathologist?
- A. No. The personnel regulations allow a variety of options for the education and experience combinations to qualify as director. A physician with at least one year experience directing or supervising moderate or high complexity testing can continue to do so; if you do not have this experience you may obtain 20 CME hours in laboratory practice within one year to qualify. Also, doctoral, master's, or bachelor's degrees in the sciences with appropriate training and experience can qualify.
- Q. Can nurses and medical assistants continue to perform laboratory testing?
- A. Yes, in most cases. For moderate complexity testing, personnel must have, at minimum, a high school education and documentation of satisfactory training appropriate to the tests performed; this training may be on the job or formally obtained. For high complexity testing, specific formal education is required.
- Q. Do I have to change the way I perform laboratory tests?
- A. Perhaps. If you have not been performing adequate quality control you will need to begin doing so and documenting the results. For the first two year phase-in period, if you are performing moderate tests with kits or devices cleared by the FDA, you must at minimum, follow the manufacturer's instructions, prepare a procedure manual, run two level of controls each day of use, document calibrations at least every six months, and take remedial action when indicated. By 1994, the FDA will be clearing manufacturer's instructions for QC compliance and you will be able to meet the requirements by following those approved instructions.
- Q. What is proficiency testing and how does it apply?
- A. Proficiency testing (PT) is an external evaluation of laboratory test performances. Approved commercial programs provide sets of unknown specimens for you to evaluate in the same manner as you test patient samples. You will receive five samples in each of three shipments per year. Your result will be evaluated against a target range or consensus answer. Generally, you must obtain a grade of 80% to pass. You will not be penalized for a single failure, but must take steps to identify or correct problems to avoid future penalties. Newly regulated labs must enroll during 1993 and begin to participate by 1994.
- Q. How much do proficiency test programs charge?
- A. It depends. If you perform very few of the PT regulated tests, your annual costs will be in the hundreds of dollars range; labs performing most of the PT regulated tests will be in the thousands of dollar range.
- Q. What are the fees for a certificate?
- A. Initially, all laboratories will have to pay \$100 for a certificate of waiver or \$100-600 for a certificate of registration (varies due to test volume and specialties). Inspection fees vary from \$300 to several thousand dollars dependant on test volume and specialties. Inspection and waived fees will be assessed every two years.
- Q. What are the test specialties that influence the inspection fees?
- A. Test specialties and some test examples are:
- Microbiology -- cultures, rapid strep, wet mounts for yeast
  - Serology -- RPR, mono-test, rubella
  - Chemistry -- glucose, thyroid profiles, pregnancy, drugs
  - Hematology -- hematocrit, red and white cell counts
  - Immunohematology -- ABO group, Rh type
  - Pathology -- Pap smears, tissue studies
  - Radioassay -- in vivo isotope studies, Schillings
  - Histocompatibility -- HLA typing
  - Cytogenetics -- chromosome analysis
- Q. How do I count my tests to determine annual volume for fee purposes?
- A. Waived test volume is not counted for a waived certificate or when performed at a site also conducting moderate or high complexity tests. Each moderate or high test procedure is counted. If, for example, you run a profile of chemistry tests that includes six procedures, each is counted separately.
- Q. How do I get started?
- A. Obtain an information form and return it to HCFA. You may request one through the Denver HCFA office at 844-4726 or the Baltimore "CLIA Inquiry Hotline" at (410) 290-5850.

# Physician Employers and the

Employers should start now reviewing employment procedures, recruiting, job descriptions, benefits and accommodations

*"...the ADA prohibits discrimination in all employment practices ..."*

"The Americans With Disabilities Act gives civil rights protection to individuals with disabilities similar to those provided to individuals on the basis of race, sex, national origin and religion. It **guarantees** (emphasis added) equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications." So says Dick Thornburgh, Attorney General, in a publication distributed by the U. S. Department of Justice, Civil Rights Division, Office on the Americans with Disabilities Act.

As you can see, the ADA has far-reaching implications. And rather than try to cover all aspects of the Act, only the most common issues regarding the area of employment will be addressed.

First of all, private employers, state and local governments, employment agencies and labor unions are all covered by the Act. Employers with 25 or more employees must comply beginning July 26, 1992, and employers with 15 or more employees must comply two years later, beginning July 26, 1994.

Compliance in the context of employment means the ADA prohibits discrimination in **all employment practices** including job application procedures, hiring, firing, advancement, compensation, training, and other conditions of employment. It also applies to other employment-related activities such as recruitment, advertising, seniority, layoff, leave and benefits.

In order to comply, you will want to review each of the areas mentioned above to assure that protected

individuals are not discriminated against. The ADA defines an "individual with a disability" in three ways...as a person who: 1) has a physical or mental impairment that substantially limits one or more major life activities; 2) has a record of such an impairment; or 3) is regarded as having such an impairment. These must be impairments that limit major life activities such as seeing, hearing, speaking, walking, breathing, performing manual tasks, learning caring for oneself, and working. In other words, an individual with epilepsy, paralysis, a substantial hearing or visual impairment, mental retardation, or learning disability will be covered.

Examples of a "record of impairment" are a person who has had cancer that is currently in remission, or a person with a history of mental illness. "Regarded as having such an impairment" protects individuals who are regarded and treated as having a substantially limiting disability, even though they may not have such an impairment. For example, a severely disfigured person could not be denied employment because an employer feared the "negative reactions" of others. Furthermore, **individuals who have a known association or relationship with a disabled person are also protected.** That is, this provision protects a person with a disabled spouse from being denied employment because an employer fears the applicant would have excessive absenteeism in order to care for the spouse.

Next, there is the issue of who is a "**qualified**" individual with a disability. The Act defines it this way.



# Americans With Disabilities Act: Are You Ready?

by Myron L. Treber  
Director, Human Resources  
Copic Insurance Company

It is a person who meets legitimate skill, experience, education or other requirements of a job, and who can perform the "essential functions" of the job **with or without** reasonable accommodation. And this leads to one of the most important elements of compliance: job analysis. As an employer, you will want to clearly identify the essential functions of each job, in addition to other job criteria. The importance of this process cannot be over-emphasized. Why? Because if a written job description has been prepared prior to advertising or interviewing applicants for a job, this will be considered evidence, although not necessarily conclusive evidence, of the essential functions of the job.

Of course, requiring the ability to perform "essential functions" does not relieve the employer of considering a disabled person for employment. Recall the point made earlier about performing the "essential functions" with or without reasonable accommodation. Basically, here is what "reasonable accommodation" means. It is any modification or adjustment to a job or the work environment that will enable a qualified applicant or employee with a disability to perform essential job functions. A few examples might be: making your facility readily accessible to, and usable by an individual with a disability; restructuring a job; modifying work schedules; acquiring or modifying equipment; and providing qualified readers and interpreters, to name a few.

Finally, what about the question, "Does the ADA take safety issues into account?" The answer is yes. Employers may establish standards

that will exclude individuals who pose a direct threat or significant risk to the health and safety of others, if that risk cannot be lowered to an acceptable level by reasonable accommodation. One brief word of caution, however: As an employer, you cannot assume that a threat exists; you must establish through objective, medically supportable methods that a threat or genuine risk could occur in the workplace.

There are those who fear increased litigation as a result of enforcement of the Act. And I'm certain that some is inevitable, as it will require some test cases to establish precedent. That's why I encourage you to use this time before the effective date of the Act to adjust your jobs, policies and procedures to conform to the ADA requirements.

In Rotary, we have 4 questions we ask of the things we think, say and do. They are called the Four Way Test. One of the questions asks: "Is it FAIR to all concerned?" And another asks: "Is it BENEFICIAL to all concerned?" The ADA assures all qualified disabled employees of being treated fairly with regard to their employment. It is fair to the employer because we have the opportunity to clearly delineate the essential functions of the job. I believe the Act is beneficial to all concerned because it allows qualified disabled persons to be gainfully employed. It also motivates employers to re-evaluate how a job may be done which may result in improved efficiency. Will you be able to answer "Yes" to these two questions as you prepare for compliance with the ADA?

*"... one of the most important elements of compliance: job analysis."*



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**ORTHOPEDIC SURGEON**—Colorado Springs—Large, multi-specialty prepaid and fee for service group seeking BC/BE Orthopedist. Guaranteed first year salary with benefits, plus incentive arrangements. Please send CV to: William R. Truitt, MD, Colorado Springs Medical Center, PC, 209 South Nevada Ave, Colorado Springs, CO 80903. 3/0492

**FAMILY PRACTICE**—Colorado Springs—Thirty five physician multi-specialty group is seeking BC/BE Family Practitioner for branch office in Colorado Springs. Fee for service and pre-paid practice. Guaranteed salary. Please send CV to: William R. Truitt, MD, Colorado Springs Medical Center, PC, 209 South Nevada Ave, Colorado Springs, CO 80903. 3/0492

**FAMILY PHYSICIAN**; Community Health Center seeks BC/BE Family Physician for group practice north of Denver. Loan Repayment opportunities. Duties include full Family Practice (including OB) with staff of seven physician. Comprehensive benefits, pail malpractice, CME, competitive salary, very attractive location. Please send CV or inquiries to David Myers, 1115 2nd Street; Fort Lupton CO 80621, or call (800) 388-HEAL. 6/0292

**FAMILY PRACTICE** associate, Boulder, Colorado. Busy Two person practice seeks third BC/BE full or part time associate. No OB. Call L. Wood, MD at (303) 444-8835 for information. 6/0292

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# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

1992

Volume 89, Number 8

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## This Issue:

Special Insert, 1992 Annual Meeting — Complete program

Doctor Bashing - Can have disastrous results..... by Harrison G. Butler, III, M.D. President, CMS

Decade of the Child-Special Section: by Mildred Doster, MD; Richard E. Hoffman, MD, MPH; Robert McCurdy, MD, MPH

Immunization - New Requirements.....by Lynn Livingston, Staff, Health Care Policy Division

ADA: Can you comply? Some help from Colorado Department of Social Services.....by Sandra Burns, ADA Coordinator

Ruminations: Where will health care reform take medicine.....by Bill Pierson, Managing Editor, *Colorado Medicine*



# Goals Vs. Performance



## **1981 Goal:**

**Work Toward Eventual Resolution of the Major  
Professional Liability Problems in Colorado**

## **1992 Assessment:**

Goal not yet reached, but we're well on the way. Item:

- Because of our determination to defend non-meritorious claims the plaintiffs' bar has come to understand that "nuisance" claims or suits will no longer be profitable to them.



## **The bottom line for Copic:**

provide Colorado physicians and, indirectly, the people  
of the state with professional liability insurance which  
is affordable, equitable and fair.

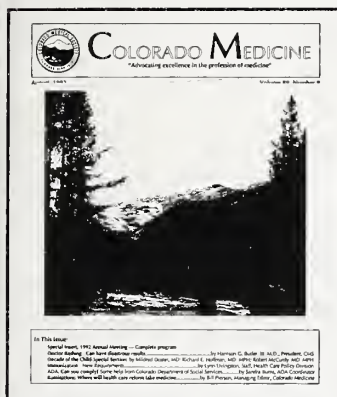




# COLORADO MEDICINE

August, 1992

Volume 89, Number 8



## Cover Story

For the 122nd time, the House of Delegates meets in Annual Session, but there is more to the meeting than just business. See the enclosed insert.



## DEPARTMENTS

- 255 President's Letter
- 257 Executive Director's Update
- 276 Health Care Financing
- 280 Committee Update
- 281 Board of Directors Highlights
- 283 Copic Comment
- 284 Medical News
- 287 Ruminations
- 291 Classified Advertising

## In This Issue...

- 255 **Doctor Bashing**—Can have disastrous results  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 258 **Decade of the Child**—A Special Section  
**Contributors:**  
*Mildred Doster, M.D.*  
*Colorado Medical Society representative to the Colorado Department of Education's Advisory Council*  
*Richard E. Hoffman, M.D. MPH*  
*State Epidemiologist*  
*Robert McCurdy, MD, MPH*  
*Director, Medical Affairs*  
*Colorado Department of Health*
- 264 **Immunization**—New Requirements  
*by Lynn Livingston, CMS staff*
- 266 **Medical Training in Costa Rica**  
*by Gil Maestas, II, Colorado Medicine staff*
- 270 **Americans with Disabilities Act: Practical Information**  
*by Sandra D. Burns*  
*ADA Coordinator Colorado Department of Social Services*
- 274 **Non-Physician Medical Care**  
*by Mary Jean Berg, M.D., Chair*  
*CMS Council on Medical Service*
- 279 **Abraham Lincoln: Malpractice Defense Attorney**  
*by Gwilym B. Lewis, MD*



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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor

Member, Colorado Press Association,

Member, Colorado Broadcasters Association





*Harrison G. Butler, III, MD  
President, 1991-1992*

## More Doctor Bashing

Events of the last month reinforce the need for a state medical society. These events also show the breadth and depth of the enmity for physicians held by many, if not most of the state bureaucrats. These same individuals are Johnny on the spot when it comes to asking for our cooperation when it suits them, but I have seen little recent reciprocal cooperation. All we seem to get is the bureaucratic run around, smokey room deals and double talk disguised as concessions.

Let's discuss just one example: House Bill 1306. This was a bill passed during the last legislative session and signed by Governor Romer, despite vigorous opposition by the Colorado Medical Society, other specialty societies, ambulance companies and vendors. HB 1306 affects Medicare/Medicaid patients and the practical results is that the co-pay which was once picked up by Medicaid will no longer be paid. In case you did not notice, for these patients, you just took another 20% cut. This comes on top of steadily decreasing reimbursement for Medicaid patients, so that it actually costs more to see the patient than you are being reimbursed. In one sense, we can actually make money by not seeing Medicaid patients. Take for example, routine nursing home visits for Medicaid patients being reimbursed at the ridiculously low sum of \$9.84.

The Colorado Medical Society provided position statements and I personally testified against this bill, pointing out that at these rates, there

would be an access problem. Don't lose that thought as I will return to in a moment.

I was told by the staff of the HEWI committee that they understand our concerns and they asked us to submit changes, which we did. We were also assured that this matter would not be considered again that day. However, Medicaid was able to pull a shenanigan and get this reconsidered and had our amendments thrown out without any chance for us to state our side of the story. The Senate then rushed this bill through and got it passed. The Senate leadership stated "The doctors will just have to understand."

It is clear that neither the Senate nor Medicaid realizes it is not the doctors, but the PATIENTS who have to understand. They also do not grasp the fact that the physicians who care for these patients cannot be expected to underwrite the state program. These leaders and "crats" apparently hold physicians (as well as patients) in such low esteem that they act as if they prefer not to be distracted by the facts. This is not the first time that the effects of legislation on patients have been ignored in an attempt to balance the budget and also "get the rich doctors".

Remember how we warned that this piece of legislation would cause access problems? Lo and behold, we received a call at the CMS from Medicaid asking us to discuss a crisis caused by an access problem. Apparently, there were patients in acute-care hospitals that could not be admitted to nursing homes because physicians were not available. We attended this meeting and

*"Let's discuss just one example: House Bill 1306."*

# Doctor Bashing...cont.

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*"The only true influence that physicians appear to have and the only true way to influence policy making entities is in our numbers, speaking with one voice."*

were told by Medicaid how physicians were abusing them and their program. Further, we were pointedly told that an example of this abuse was how physicians had many patients on 15-20 different medications. This in spite of the fact that the CMS has supported and is participating in the Medicaid Drug Utilization Review Committee. We continue to be supportive of that concept, but of course, this was conveniently overlooked.

After an hour and a half, of mostly wasted time, a deal was struck with a single group of physicians in a classic divide and conquer maneuver. That deal is as follows: three codes, affecting only Medicare/Medicaid nursing home patients, will be reimbursed at their previous levels, but only until September 1, 1992. This way, Medicaid cynically postponed this crisis but only with a small group of physicians, who admit and care for these patients in nursing homes. Do not misunderstand my position. I support these physicians in that I feel they should be fairly reimbursed for the care that they give. But this begs the larger issue of fairly reimbursing all physicians who take care of Medicare/Medicaid patients. Although the CMS agreed to accept this too little, too late short term partial "code adjustment," it remains adamantly opposed to the root cause of the problem.

This is simply another form of

doctor bashing. The legislature is attempting to balance the budget on the backs of the sick and the poor, then trying to blame the physicians for the suffering it causes. Make no mistake, the CMS will be back at the next legislative session and will attempt with all the resources we can muster to get this bad legislation repealed. The CMS will also continue to cooperate in the most effective manner that it can with those government entities that can benefit from our assistance. However, we will not be manipulated or bullied by politicians and the "crats", especially when it involves quality of care issues.

The CMS will continue to resist divide and conquer tactics. These issues demand and will get unanimity of opinion and effort by all of organized medicine.

The only true influence that physicians appear to have and the only true way to influence policy making entities is in our numbers, speaking out as one voice. We are now entering into the hardball big leagues. Physicians and medicine are under unprecedented attack and we have few, if any, allies. Until physicians are willing to commit to fight for what we believe in and what is fair, with the same tenacity and ruthlessness as our adversaries, we will continue to lose miserably. Most importantly, our patients will continue to be sacrificed to the God of political, bottom-line medicine.



# CMS Med Fax<sup>®</sup>

**AT PRESS TIME...**

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

CMS Med Fax<sup>®</sup>

by *Montgomery Little Young Campbell and McGrew, P.C.*

legal counsel to the Colorado Medical Society

## ALERT!

**IF YOU HAVE A LARGE MEDICARE/MEDICAID PRACTICE, HB 1306, CONCERNING the Delivery of Services Pursuant to the "Colorado Medical Assistance Act" Through Managed Care, affects you!**

HB 1306 was proposed by the Department of Social Services to alleviate the shortfall in Medicaid funding and is now law.

CMS recognized the problems faced by the Joint Budget Committee and the legislature in dealing with the state's large budget deficit and agreed that portions of HB 1306 should increase the cost effectiveness and medical appropriateness of the Colorado Medicaid Program. These include: (1) the implementation of managed care principles, and (2) mandatory selection of a primary care physician. The medical society supported these sections, but voiced strong opposition to Section 26-40-404 (b) (1) of the bill which mandates that the Department of Social Services pay the lower of Medicare/Medicaid reimbursement therefore, eliminating the co-insurance payment by Medicaid, when individuals have dual eligibility.

CMS leadership and staff argued that the lower reimbursement rate would seriously impact access to medical care, especially for nursing home patients. We repeatedly stated our fear that this action would heighten the crisis that already exists by further diminishing the number of qualified physicians who are willing to treat Medicare/Medicaid patients.

There were unsuccessful attempts made to amend this section out of the bill which passed during the final days of the 1992 legislature. At this point, CMS requested a veto by Governor Romer. He signed the bill on May 21, 1992.

Our worst fears were realized during the past month when a large geriatric and rehabilitation services group faced a major crisis. These physicians determined that they could not afford to accept new dual eligible patients due to the decreased reimbursement levels. The Department of Social Services was gravely concerned and agreed to increase reimbursement for three nursing home codes to 100% of Medicare's current rates as a

temporary measure need to restore access. This increase will only cover the period of July 1 through September 30, 1992 and is intended to allow the department, CMS, and other interested parties to consider a long term solution to the problem.

Has your practice been negatively impacted? If so, we recommend you enlist the assistance of your patients in contacting our state legislators to request their help in addressing this problem during the coming year.

Please do not hesitate to contact the CMS Department of Government Relations if you have questions or would like a copy of HB 1306. (779-5455 or 1-800-654-5653).

You will find below a sample letter to patients. You may copy this in your office for distribution or write your own letter to your patients.

### Dear Patient:

### Help me continue as your physician

I want to continue as your physician and I need your help! I am currently facing a 20% reduction in payment when I treat patients with both Medicare and Medicaid insurance. This reduction in payment is due to legislation passed by the Colorado State Legislators via House Bill 1306. In most instances Medicare and Medicaid dollars, eliminated by HB 1306, acted as a co-payment to try to help reduce the gap between the true cost of providing care and what was actually paid by Medicare.

I recognize my responsibility to care for my patients, but I also feel that the State of Colorado should share in that responsibility and make fair payment for my services. Please feel free to discuss this issue with me. I am asking for your support. It is crucial to bring our

(Continued from preceding page)

concerns to the attention of those who have the authority to change this unfortunate situation. Following is a list of Colorado Legislators active in this new legislation.

**Governor Roy Romer**

Governor's Mansion  
400 E. 8th Ave.  
Denver, Co 80203

(303) 866-2471

**Senator Michael C. Bird**

5810 Spurwood Ct.  
Colorado Springs, CO 80918  
(303) 866-4866

**Senator James Rizzuto**

Box 215  
La Junta, CO 81050  
(303) 866-4865

**Senator Claire Traylor**

4045 Field Dr.  
Wheat Ridge, Co 80033  
(303) 866-4866

**Representative Tony Grampsas**

3237 S. Hiwan Dr.  
Evergreen, CO 80439  
(303) 866-2957

**Representative Betty Neal**

759 S. Hudson St.  
Denver, CO 80222  
(303) 866-2937

**Representative Gilbert Romero**

1128 Catalpa St.  
Pueblo, CO 81001  
(303) 866-2587

If you are unable to contact the above listed legislators, it is always effective to contact your local Senator or Representative. To obtain the names of your legislators, contact your County Clerk (listed in the blue Government Listings in the phone book under County Government.)

## Daniel Ellsberg to Keynote Conference

Daniel Ellsberg of "Pentagon Papers" fame will keynote a conference sponsored by Physicians for Social Responsibility. (PSR)

The conference will take place at Denver's Children's Hospital on September 26, 1992.

Ellsberg is a former State Department and Defense official. During this period of time, he drafted the Kennedy administration guidance for nuclear war plans. At the present time, Mr. Ellsberg is director of *Manhattan Project II* at PSR. the Manhattan Project II is an action that specifically calls for the following.

- 1) For President Bush and President Yeltsin to end nuclear testing permanently.
- 2) To commit to a mutual ceiling of 1,000 warheads or less.
- 3) To adopt a "no-first-use" policy.
- 4) To verifiably eliminate all tactical weapons.
- 5) End production of fissionable materials for weapons.

An additional lecture will be given by Dr. H. Jack Geiger. Dr. Geiger is a Logan Professor of Family Medicine, at City University of New York Medical School and is the principal author of "Dead Reckoning" a critical review of the Department of Energy's epidemiologic studies on the health of workers at nuclear weapons plants.

An Informative discussion will conclude the day's events. Panelists include former Colorado Governor Dick Lamm, Dr. William J. Weida of Colorado College and nationally recognized expert of economic conversion, Terry Vaeth, U.S. Department of Energy, Rocky Flats and Dr. Patricia Nolan, Executive Director, Colorado Department of Health.

Cost for the full day including lunch is \$12.50 per person.

For additional information call Jody Taylor, executive director, Physicians For Social Responsibility.



## Med Fax: Medico-Legal News

by Karen Best, Esq., an Associate  
with the firm of Montgomery Little

Young  
Campbell & McGrew, PC

*This column is not legal advice, but is for general  
information only. For help with specific problems,  
readers should consult an attorney.*

### THE ADA OF 1990: QUESTIONS AND ANSWERS

Because of the ADA's recent effective date (January 1992 for Title III), we have no case law to consult for interpretation of its provisions. For now we can only apply the basic terms of the Act and the legislative history, to different scenarios and predict the outcome. This requires some crystal-ball gazing.

**Q.** Does a deaf patient have the right under the ADA to bring his own interpreter to the doctor's office for an appointment and demand the doctor pay for the interpreter's services during the office visit?

**A.** There are two questions here. First, does the patient have the right to choose the type of auxiliary aid or service to be provided? No. The ADA does not give the patient that right. The doctor determines what aid or service will result in effective communication between doctor and patient, based upon the factors described in the ADA (complexity of information, undue burden, fundamental alteration of the service offered). The circumstances may not require the presence of a qualified interpreter at all. The goal is effective communication. If the decisions made by the doctor does not result in effective communication, there has been a violation of the Act. Second, if the circumstances do warrant the services of an interpreter, must the doctor pay? The doctor will end up paying for the interpreter used, who may or may not give the patient the right to choose the interpreter.

**Q.** The examination of a disabled patient takes twice as long as the examination of other patients. May the doctor bill the disabled patient extra because it takes longer to carry out the examination? May the doctor bill Medicare, Medicaid or private insurance for an extended visit, or must the doctor limit his charges to the amount billed non-disabled patients for the same type of examination?

**A.** The ADA does not answer this question directly. However, the Act prohibits charging disabled patients for aids or services provided because of the disability. If challenged I predict the court would consider the nature of the service rendered, not the time taken to provide the service, in determining whether the billing practice discriminates against the disabled. Using this analysis, I predict the court would find a violation. This is an area to watch.

**Q.** Can Doctors charge a blind patient extra for the additional expense of providing brailled written materials? How about spreading the cost over all blind patients? How about spreading the expense of all auxiliary aids and services among all patients with disabilities?

**A.** No. To spread the cost at all, it must be allocated equally to all patients.

**Q.** Would asking a family member or close friend to act as a qualified interpreter, when the doctor explains to a deaf patient major surgery or other serious of complicated matters, be acceptable under the act?

**A.** The Act does not prohibit this practice. However, the doctor must consider whether emotional or personal involvement with the patient, or confidentiality concerns, will adversely affect the ability to interpret or communicate effectively, accurately, and impartially.

**Q.** Can a doctor maintain an office on the second floor of an old (existing) building even though there is no elevator?

**A.** Yes. However, all newly constructed buildings housing a doctor's office must have an elevator.

**Q.** Does the Act require doctors to provide written informed consents in braille to blind patients?

**A.** No. If an alternate aid or service is available brailled materials are not necessary. For example, the doctor or a staff member could read the information.

**Q.** Does the Act require a telephone in doctor's offices which would allow deaf patients to call out?

**A.** No. Telephones in doctor's office are incidental and are not part of the services provided. However, in hospitals where calling out is a service offered to all non-disabled patients, the Act would require aids or services for the hearing impaired; for example, telephone handset amplifiers, telephones compatible with

hearing aids, telecommunication devices for the deaf  
(Continued from preceding page)  
(TDD) , closed captions or decoders.

**Q.** Does referring an alcoholic to a doctor specializing in alcoholism and its consequences violate the Act?

**A.** No. Referral is proper when the disability itself creates specialized complications for the patient's health that the physician lacks the experience or knowledge to address.

**Q.** Would a physician's refusal to treat a drug addict, based upon the patient's present use of illegal drugs, violate the ADA?

**A.** No. Drug addicts who are currently using illegal drugs are not protected by the Act, while those who are in a rehabilitation program or who are former addicts are protected.

**Q.** Is refusing to treat an HIV positive patient "discrimination" under the Act if the doctor believes that treating the patient poses a direct threat to his/her health or safety?

**A.** HIV positive individuals are protected by the Act. Whether refusing to treat would violate the Act depends upon several factors: The nature of the treatment — Is the patient requesting hip replacement surgery or treatment for a cold? Would treating the patient pose a significant risk to the health or safety of the doctor? The answer must be based upon reasonable medical judgment which relies on current medical evidence or the best available objective evidence concerning the severity of the risk, the probability that a potential injury will actually occur, and whether reasonable modification of practices or procedures substantially reduce the risk. Generalization and stereotypes about the effects of any particular disability are not enough.

**Q.** Can a doctor refuse to allow a blind patient to bring his/her seeing eye dog into the examining room because the dog carries germs?

**A.** Prohibiting service dogs from entering public accommodations, such as doctors' offices, violates the Act. However, the dog need not accompany the patient to the examining room. An office member could escort the patient to the examining room and provide whatever service necessary to ensure the safety of the patient. Whether the dog would pose a direct threat to the health or safety of others is another consideration, but not a strong peg to hang your hat on.

**Q.** A hospital or health care provider offers parenting classes specially designed for mentally retarded, emotionally ill or learning disabled patients. Does this violate the ADA?

**A.** No. However, they cannot at the same time prohibit the disabled from attending parenting classes offered to other patients.

**Q.** Is a person with the flu considered disabled under the Act?

**A.** No, because the flu is transient and does not substantially limit a major life activity. However, some disabilities do come and go, such as back problems.

Each case brought under the ADA will serve as a test case refining and defining its terms. The Act both directs and challenges physicians to establish practices that will allow disabled individuals equal access to their essential services.



## **Robert Wood Johnson Foundation Approves Colorado Universal Health Care Study Grant\***

\*Information provided by Governor's Press Office

Governor Roy Romer announced August 3rd that Colorado is one of 12 states which have been awarded Robert Wood Johnson Foundation grants to study innovative approaches to providing universal health care and containing the escalating cost of care.

Romer said that Colorado has received a two-year, \$566,999 planning grant to study the feasibility of providing universal health care for all residents of the state. The grant was announced at a news conference held during the summer meeting of the National Governors' Association.

The Colorado Trust earlier announced its intention to provide an additional \$100,000 of support.

"This grant is very important to Colorado and to its future," Romer said. "It will provide us with the financial support necessary to begin to work toward providing affordable health care to every Coloradan and to begin to work toward the possibility of controlling health care costs at the same time. 'I am convinced that health care is one of the most critical issues facing this state and this nation. We must find workable solutions and I believe that states can take the lead and work effectively toward this goal.'"

The Governor said that the grant was sought as a result of the cooperative work of the Colorado Legislature, the Governor's Office and the state's health care community.

The study, to be conducted out of the Colorado Governor's Office, will be based on groundwork laid in the ColoradoCare proposal, developed by the Colorado Coalition for Health Care Access.

The ColoradoCare proposal would pool all existing public and private funds now used to pay for health care for residents of the state. The study will investigate

whether that money then could be used to contract with a limited number of health care insurers and HMOs to provide a range of health care benefit options. Each year, every eligible Colorado resident would be able to select from among the qualified plans.

Romer said competition among the private providers would be expected to create strong incentives to control costs. However, the study will examine additional cost containment mechanisms.

A total of 35 states competed for the grants. After the first two years, Colorado can apply for a three-year continuation of the grant for implementation purposes.

## **Women's Health Issues 1992**

Congresswoman Patricia Schroeder will present a free public forum on women's health Saturday October 24, 1992. Medical professionals and health care advocates will present current medical information on the following topics:

- Mental Health
- Menopause
- Aging
- Chronic Disease
- Health Care Reform
- Your Adolescent's Health Care Needs

### ***Mid Life Health Issues and The Legislative Process***

Saturday, October 24, 1992

9:00 A.M.-2:00 P.M.

University College at University of Denver  
General Classroom/Building Auditorium  
2040 Race Street  
Denver, Colorado

State and federal issues will be discussed as well as strategy for a national women's agenda.

Lunch will be provided and space is limited. RSVP by phone or fax.

# CMS Med Fax

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

## **Lovelace Medical Foundation**

### **Mammography Seminar**

Santa Fe, NM

September 7-11, 1992

Dawne Ryals, (404) 641-9773

### **Medical Education Resources**

Arrhythmias: Interpretation, Diagnosis and Management

Las Vegas NV

September 25,26, 1992

(303) 798-9682 or 1-800-421-3756

### **Medical Education Resources**

Advances In Vascular Diseases

Atlantic City NJ

September 25,26, 1992

(303) 798-9682 or 1-800-421-3756

## **Rocky Mtn College Health Association**

Annual Fall Meeting

University of Wyoming, Laramie, WY

September 25-26, 1992

1-800-448-7801 or (307) 766-2124

## **Colorado Fetal Alcohol & Substance Abuse Coalition**

Prenatal Exposure to Alcohol & Drugs

Colorado Convention Center, Denver, CO

October 2,3, 1992

Heather Jones (303) 861-6838

### **Medical Education Resources**

Advances in Vascular Diseases

Orlando FL

October 9-10, 1992

(303) 798-9682 or 1-800-421-3756

## **Univ. of Calif. Med School Dept. of Radiology**

Radiology In Africa

Nairobi, Samburu, Kenya, Masai Mara

October 10-24, 1992

Dawne Ryals (404) 641-9773

## **Lactation Program---Presbyterian/St. Luke's**

Contemporary Issues In Breast Feeding

October 16, 17, 1992

Radisson Hotel, Denver

Elaine (800) 633-6824

## **Colorado Rural Health: Creating Our Future**

sponsored by Colorado Rural Health Resource Center and Colorado Rural Health Consortium

October 16, 17 & 18\*, 1992

Hotel Colorado

Glenwood Springs, Colorado

(303) 331-8401 Fax: (303) 322-7588

### **Medical Education Resources**

Asthma and Allergy in the 1990s

Las Vegas NV

October 30-31, 1992

(303) 798-9682 or 1-800-421-3756

### **Medical Education Resources**

Advances in Vascular Diseases

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

### **Medical Education Resources**

Asthma and Allergy in the 1990s

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

## **Radiological Society of North America**

78th Scientific Assembly & Annual Meeting

Chicago, IL

November 27 - December 4, 1992

(708) 571-2670

## **Rush-Presbyterian-St. Luke's Medical Center**

Rush Symposium on Hepatic & Biliary Disease

Chicago, IL

October 30, 1992

Suzanne Buss, (312) 942-6242

## **Prosper Meniere Society**

Diagnostic & Rehabilitative Aspects of Balance & Movement Disorders

December 2-6, 1992

Denver, CO

Jane Wells (303) 788-4230





## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director

*"...to help the society keep up with the changing needs of medical practice..."*

To the best of my knowledge, the 1992 CMS Leadership Conference (Grand Junction, July 10-12, 1992) was one of the best attended and participatory conferences we have had for some years. The program was moderated by Dr. Leigh Truitt, CMS President-elect, and moved vigorously through the variety of subjects with ample discussion and input. The program also stayed on schedule.

Much thought concerning the medical future ("Physicians in the Year 2000") was provoked by two well-known speakers.

Keynoter was Richard Lamm, former Colorado Governor, speaking on demographics. Be assured that the address stirred up comment and exchange. Dr. Daniel "Stormy" Johnson, AMA Speaker of the House told attendees about AMA's role in organized medicine and how the AMA is preparing for the year 2000.

What did all this do for us? First, the conference gave CMS leaders a much better perspective of what's on the members' minds. Second, the comments and exchanges allowed the incoming president and the CMS staff to focus on issues that seem to reoccur from practice to practice and from one region of the state to another. As we review these materials we can find or develop ways to make the CMS efforts more focused. Third, fellowship and peer exchange helped understanding and even introduced some new ideas; typically, western slope physicians were able to talk about problems germane to their area and how they were dealing with the problems. Solutions were expressed which might not have been readily obvious to the

eastern slope doctor (the difference between small town and large town thinking). Drs. Roger Schenkle and Jack Berry gave excellent insight into eastern-western, rural-urban practices. Fourth, dialogue took place concerning medical students and the present role of CU Med School. CMS President Harrison Butler spoke about the current CMS efforts to aid in rural health matters, such as the planning underway to develop a CMS locum tenens program.

One of the suggestions made by panel member Dr. Gilbert Maestas of Denver was for CMS bylaws to be changed to allow for appointment of delegates to the house rather than the nomination /election process. Dr. Maestas stressed that the organization needed new and young blood, and shorter terms of office, to help the society keep up with the changing needs of medical practice and to encourage more minority participation.

Dr. Louise McDonald, CMS Women In Medicine Section, emphasized that women are playing a rapidly-increasing role in medical practice, citing statistics showing the growing number of female medical students, and the enlarging scope of female medical practice in Colorado and the U.S.

Our three panels and all the panelists (individually) were excellent. Speakers were interested and interesting. Dr. Truitt's summary and moderation of the program were both good, and we'll be having a detailed published report on his overview soon. Old friendships were renewed, and some new friendships were established. That's a good result for any conference.

# Good News for Health Promotion in Schools

by **Mildred Doster, M.D., Denver, Colorado**

*Colorado Medical Society representative to the Colorado Department of Education's Advisory Council to develop rules and guidelines for comprehensive health education in schools..*

*"We can no longer afford to ignore the fact that . . . prevention is the single most important factor in maintaining good health"*

*Louis Sullivan, M.D.  
Secretary of Health and Human Services*

## Another milestone!

The slow track towards full programs in health education occurred July 1990 when the state legislature passed the Colorado Comprehensive Health Education Act. Senator Dottie Wham (R-Denver) led the efforts along with the Junior League of Denver and other strong advocates for better health and living for our half-million school-age children and youth. The Colorado Medical Society and many other health-oriented groups lent their support to the efforts. This time even some funding (about a third of a million dollars) went with the legislation.

Guidelines for planning the new curriculae have gone out to all school districts directing them to move towards specific plans to meet their needs. They are to involve families and community leaders, etc. in the plans and classroom activities. Student participation is to be optional with parental notifications to be required prior to class participation.

The goal of the new Comprehensive Health Education Act is to enhance the current programs and promote efforts toward K-12 integrated (but age-focused) instruction to achieve optimum health choices and behavior for every student.

The CMS has advocated this for many years and can now participate more directly in the school planning or direct classroom activities. If your

school(s) is thinking of expanding or starting more health education programs this year, please help meet their needs.

Our profession has much to offer. "Wellness is fashionable now. The Federal government has recognized the impact of health promotion for everyone and health education particularly in schools. Dr. Louis Sullivan, Secretary of Health and Human Services said, "We can no longer afford to ignore the fact that individually, and as a nation, prevention is the single most important factor in maintaining good health" and -- "the U.S. death rate has begun to drop for the first time in twenty years, and most of the progress is attributed to improved lifestyle habits. Declines in smoking rates alone have saved an estimated 750,000 lives during the past twenty years. However, we are now learning that changing people's lifestyle habits is just as difficult as curing their diseases through traditional medical practices."

School health instruction reinforces healthy lifestyles in the home and community and can accomplish much for a healthier nation.

*Ed. Note: Since Dr. Doster submitted this article, several changes have been made, which further improve the status of school health education. Updates on the issue will be forthcoming in Colorado Medicine.*



# Decade of the Child in Colorado

*Excerpts reprinted from Colorado Children Campaign newsletter, Volume 4, Number 3, Winter, 1992*

In 1990, the Colorado Children's Campaign launched the Decade of the Child in Colorado, a ten-year initiative designed to make Colorado the most child-friendly state in the nation by the year 2000. A coalition of 500 businesses, community action groups, child service providers, government agencies and foundations mobilized to increase public awareness and facilitate long-term improvements in the areas of poverty, health, early childhood care and education, child support, education (K-12) and child welfare. This group set specific, quantitative goals to measure the progress of children in Colorado.

The Children's Campaign monitors the state's progress toward attaining the Decade of the Child goals and recently released its findings in the *1992 Annual Report*.<sup>\*</sup> The report card provides an insightful look at how children are faring in Colorado and a poignant picture of the problems confronting thousands of Colorado's youngest citizens. Poverty and teen pregnancy are the common threads linking many children's issues. National estimates are that the number of children living in poverty in Colorado has increased from 8% in 1980 to about 17% in 1989.

There has also been a simultaneous rise in the teenage birth rate. Dennis Brimhall, 1992 president of the Children's Campaign board and president of University Hospital concludes, "Teenage births relate directly to problems including late prenatal care, infant mortality, low birthweight babies, children in poverty and failure to graduate from high school. Lowering the teenage birth rate will cause improvement in

many other areas."

Behind each of the statistics included in the report are two stories. The first story is about real people, real children, and real families. Every number represents a family unable to realize its dream of a better life for its children.

The second story concerns the complex, interconnected political and policy options. The numbers represent important decisions that must be made to ensure that every child in Colorado gets a healthy, educated start in life.

*"The Report tells two stories. . ."*

1992 Decade of the Child Annual Report Card				
	1988	1989	1990	Goal for 2000
<b>Early Prenatal Care</b> (care received in first trimester)	77.7%	76.4%	77.8%	90%
<b>Infant Mortality</b> (deaths in first year per 1000 live births)	9.5%	8.7%	8.8%	7%
<b>Low Weight Births</b> (less than 5.5 pounds)	7.8%	7.8%	8.0%	5%
<b>Births to Teens</b> (per 1000 women age 15-19)	47%	53.6%	54.9%	25%
<b>Paternities Established</b> (per 1000 out-of-wedlock births)	167	188	162	600
<b>Children in Poverty</b>			17.6%	8%
<b>Youth Unemployment</b>	14.3%	14.0%	13.4%	7%
<b>High School Graduation</b>	NA	80.0%	78.9%	90%
<b>Deaths Due to Child Abuse</b>	26	23	28	<12
<b>Confirmed Child Abuse Reports</b>	5,617	5,929		
<b>Teenage Suicides</b> (per 100,000 teens age 10-19)	9.3%	11.0%	10.2%	3.5%
<b>AFDC Grant as % of Poverty Level</b>	44.1%	42.5%	40.5%	75%
<b>Enrollment in Preschool Programs</b> (Head Start, CO Preschool Program, Chapter 1 & Special Education)		11,777		

<sup>\*</sup>Individual copies of Volume 1 of *The Annual Report*, including an executive summary of the report, are available from the Colorado Children's Campaign at no charge. Volume 2 contains county-specific information and detailed topical analysis and is available for \$10. Either report can be ordered from the Colorado Children's Campaign, 1600 Sherman Street, Suite B300, Denver, CO 80203-1604, (303) 839-1580.

# Recommendations for Assessing Children's Lead Exposure and Screening for Lead Poisoning

Reprinted from the *Colorado Disease Bulletin*, Volume No. XIX, Issue No. 12, June 26, 1992

By **Richard E. Hoffman, M.D. MPH**  
State Epidemiologist

*"... pediatric health care providers take a lead exposure history for every child ages 6 to 72 months."*

In October 1991 the Centers for Disease Control (CDC) Published the 4th revision of its statement entitled *Preventing Lead Poisoning in Young Children*. The October 1991 statement differed from the 1985 (3rd revision) CDC statement in two principal ways: (a) the 1985 blood lead intervention level of 25 µg/dL

in this state should be universally screened for lead poisoning. As previously reported in the *Colorado Disease Bulletin* (July 19, 1991), surveys conducted in 1989 of selected children 9 months to 6 years of age in Denver, Grand Junction, and Pueblo found 4.1% to 7.7% had blood lead levels  $\geq 10$  µg/dL. The

## Sample Questionnaire

### Does your child—

1. Live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, the home of a babysitter or a relative, etc.
2. Live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?
3. Have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (that is, blood lead  $\geq 15$  µg/dL)?
4. Live with an adult whose job or hobby involves exposure to lead (hobbies such as furniture refinishing; making stained glass; making pottery; using indoor firing ranges; or employment in industries such as storage batteries; automotive repair shops; secondary smelting; bridge, tunnel, and elevated highway construction)?
5. Live near an active smelter, battery recycling plant, mining tailings piles, or other industry likely to release lead?

was revised downwards to 10 µg/dL, and a multitier approach replaced the previous single, all-purpose definition of childhood lead poisoning; and (b) universal screening of children was recommended using a blood lead measurement (rather than erythrocyte protoporphyrin level), except in communities where large numbers or percentages of children have been screened and found not to have lead poisoning.

The CDC statement, however, did not define "large percentage," and many Colorado health care providers have asked if young children

Department of Health recommended at that time that pediatric health care providers take a lead exposure history for every child ages 6 to 72 months. The purpose of this article is to provide further guidance to practitioners in Colorado.

The Department recommends that starting at 6 months of age, pediatric health care providers should discuss childhood lead poisoning with parents and assess every child's risk for high-dose exposure. We have provided the CDC's sample questionnaire for assessing risk, but the questions



asked should be tailored to the likely sources of exposure in the community. Children's blood lead levels increase most rapidly at 6-12 months and peak at 18-24 months. We recommend that the questionnaire should be repeated at regular well-child office visits, i.e. 1 year, 2 years, 3-4 years, and 5-6 years of age.

If answers to the questionnaire indicate that the child is at risk for high-dose lead exposure, the child should have a blood lead measurement. For children previously at low risk, any history suggesting that exposure to lead has increased should be followed up with a blood lead test.

In the January 24, 1992 issue of *The Colorado Disease Bulletin*, four commercial laboratories in Colorado which perform blood lead analysis and participate in CDC's laboratory proficiency testing program were listed. The laboratories are: (a) Advantage Labs, Denver, (303)271-0484; (b) Analyttox Inc., Denver, (303)792-2869, (c) MetPath Lab Inc., Denver, 303-758-2655; and (d) National Health Laboratories, (303)792-2600. The ubiquity of lead in the environment makes contamination of specimens during collection a major source of error, especially when measuring blood lead at low concentrations. Since blood collected by venipuncture has low likelihood of contamination compared to blood collected by fingerstick, venous blood is the preferred specimen for analysis; however, venipuncture is not always practicable. Fingerstick or heel stick collection methods have been developed, although there is greater potential for environmental contami-

nation with these methods than venipuncture. Before selecting equipment for use in blood collection, consult with the laboratory about its requirements. In some cases, the laboratory or instrument manufacturers may supply collection materials that are pretested for lead content.

If the blood lead level is 10-14  $\mu\text{g/dL}$ , the child should be screened every 3-4 months; once two consecutive measurements are  $<10 \mu\text{g/dL}$  or three are  $<15 \mu\text{g/dL}$ , the child should be assessed and/or retested in a year. If the blood lead level is 15-19  $\mu\text{g/dL}$ , the child should be re-screened every 3-4 months, the family should be given education and nutritional counseling (for further information, contact the Epidemiology Division at 331-8330), and a detailed environmental history should be taken to identify any obvious sources of lead exposure. If venous blood measurements on two consecutive tests 3-4 months apart are in the range of 15-19  $\mu\text{g/dL}$ , environmental investigation and abatement should be conducted. If the blood lead level is  $\geq 20 \mu\text{g/dL}$  and a repeat test confirms the initial measurement, the child should receive medical evaluation by an experienced provider. Children with blood lead levels  $\geq 45 \mu\text{g/dL}$  should receive urgent medical and environmental follow-up. Symptomatic lead poisoning or a venous blood lead concentration  $\geq 70 \mu\text{g/dL}$  is a medical emergency, requiring inpatient chelation therapy. For further information, contact the Epidemiology Division of The Colorado Department of Health at 331-8330.

*"...the child should receive medical evaluation by an experienced provider."*

# Prevention of Low Birthweight Births by Reduction of Behavioral Risks During Pregnancy

by Robert McCurdy, MD, MPH  
Director, Medical Affairs  
Colorado Department of Health

The low birthweight (less than 2,500 grams) rate in Colorado is among the highest in the nation, at a level of 8.0% in 1990. Four types of risk factors are associated with low birthweight (LBW): prematurity, high altitude, medical risks and behavioral risks. Prematurity does not explain Colorado's high rate of LBW since the prematurity rate (less than 37 weeks gestation) in Colorado is much lower than in the U.S. (8.4% vs. 10.6% in 1989). Altitude and medical risks are contributing factors but they cannot always be altered for most Colorado women. Furthermore, high altitude does not provide an adequate explanation: neighboring Utah, another high altitude state, consistently has very low LBW rates, e.g., 5.7% in 1989.

The Colorado Department of Health made a commitment in 1983 to reduce the state's high LBW rate through reduction of **behavioral** risks. The Department conducted a demonstration project which addressed changes in **high risk behavior** of pregnant women. The project tracked 988 pregnant women, at behavioral risk but without medical risk, to determine whether there was a difference in LBW rates in women who resolved or decreased their behavioral risks and those who did not. Women enrolled in the project smoked or used alcohol in any amount, or were underweight at the time of conception, or gained weight inadequately during pregnancy. All women received prenatal services **and** counseling on behavioral risks. The most common risk of the women in the project was smoking (63% smoked at the time of their first visit). 48% of the women did not gain weight adequately at some time

during the pregnancy and 30% were underweight at the time of conception. 30% reported using alcohol at the time of their first prenatal visit. 77% of the women were white non-Hispanic, 18% were Hispanic, 5% were Asian or Black, and 87% were 18 years or older. Most women had at least two behavioral risks; smoking and prepregnancy underweight were common.

Large proportions of the women eliminated or reduced their behavioral risks of LBW, despite the fact that they began prenatal care relatively late (only 25% had their initial visit during their first trimester). 29% of the women who smoked quit completely, 79% of the women using alcohol quit completely, 53% of the women who were underweight at conception gained adequately during pregnancy, 65% of the women who had weight gain problems during pregnancy reached their target weight at the end of pregnancy, and 38% of the women eliminated **all** of their behavioral risks.

Complete risk information through the entire pregnancy was obtained on 632 women. The women who resolved their behavioral risks had LBW rates lower than those who did not resolve their risks. Women who resolved **all** risks had an LBW rate of 3.7%; those who did not resolve all risks had a rate of 11.1%. Women who overcame prepregnancy underweight had an LBW rate of 5.4%; those women who overcame prepregnancy underweight **and** smoking had an LBW rate of 0.0%; while those who did not overcome both of these risks had a rate of 12.8%. Women who had the risks of inadequate weight

gain during pregnancy **and** were underweight at conception and resolved these risks had a rate of 4.5%; those who did not had a rate of 21.9%. All of these differences were statistically significant ( $p < .05$ ). Women who resolved their smoking risk had a rate of 6.8%, those who did not a rate of 10.0% ( $p < .01$ ). The LBW rate for women who resolved the risk of alcohol use was 5.8%; for those who did not 10.2% (not statistically significant, probably due to low numbers).

Logistic regression analysis identified the following behavioral risk factors as being statistically significant predictors of LBW: smoking at either the first or last clinic visit, not resolving prepregnancy underweight by the final prenatal clinic visit, and not resolving inadequate weight gain during pregnancy. Women without any of these behavioral risks had an LBW rate of 3.2%. Women with one of the risks had a rate of 7.6%. Women with two of the risks had a rate of 15.2%. Women with all three of the risks had a rate of 30.8% ( $p < .001$ ).

These data from the Colorado Low Birthweight Prevention Project demonstrate that among women with no medical risks, reduction of behavioral risks for LBW births is associated with reduced low birthweight rates. Additional information, educational pamphlets, consultation and training for staff in counselling pregnant women to resolve their behavioral risks are all available from staff at the Colorado Department of Health. Please contact Nancy Salas at 331-8572 or Dr. Robert McCurdy at 331-8373.





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# Additional Changes to

“...a new pertussis vaccine, DTaP, became available”

The August 1991 issue of *Colorado Medicine* contained an article outlining changes to immunization requirements which were approved by the Colorado Board of Health in May of 1991. Since that time, additional changes have been adopted in Colorado and nationally.

## New Acellular Pertussis Vaccine Available for Fourth and Fifth Shots

At the national level, the Centers for Disease Control have recommended an acellular pertussis vaccine for the fourth and fifth shots. After the 1991 pamphlet *Diphtheria, Tetanus, and Pertussis: What You Need To Know* was prepared by the US Department of Health and Human Services, Public Health Service, Centers for Disease Control, a new pertussis vaccine, DTaP, became available for the fourth and fifth doses. This new acellular pertussis vaccine is made of only a few parts of the pertussis cell and combined with diphtheria and tetanus vaccines, whereas the DTP vaccine is made from killed whole pertussis cells and mixed with diphtheria and tetanus vaccines. The DTaP vaccine is licensed only for use as the fourth and fifth doses which are usually given to children 15-18 months old and 4-6 years old respectively; it is not licensed for use among children age <15 months, on or after the seventh birthday, or for the initial three-dose series in infants and children, regardless of their age.

The following excerpt, reprinted from the Supplement to the above mentioned DTP pamphlet provides more details.

Whole-cell DTP vaccine should still always be used for the first three shots, and can still be used for the fourth and fifth DTP shots, although most experts will prefer to use DTaP vaccine.

Compared with the DTP vaccine, after DTaP shots fewer children will be cranky or drowsy, have fever, or have soreness or swelling where the shot was given. Convulsions that occur after receiving DTP vaccine are usually caused by fever. With DTaP, there is less chance of fever, so convulsions probably occur less often. Experts do not know whether unusual, more serious problems which have been reported after DTP vaccine happen less often after DTaP shots than after DTP shots.

If the health-care provider determines that a whole-cell DTP shot should not be given, DTaP also should not be given. In that case, the child should usually get DT vaccine instead.<sup>1</sup>

## Additions to School Entry Immunization Requirements

In November of 1991, The Colorado Board of Health approved further changes to school entry immunization requirements. These changes mandate that mumps and



# Immunization Requirements



by Lynn Livingston  
Health Care Policy Staff

rubella doses be given to 7th graders and college freshmen. Additionally, Senate Bill 122, which became law in April, 1992, set forth exclusions to the school entry rule for certain types of non-traditional colleges and universities.

The most current school entry immunization requirements appear below with the November 1991 and April 1992 additions in bold type.

## **School/Child Care/College Affected**

In the rules, "school" is defined as a public, private or parochial nursery school, day care center, child care facility, family care home, head start program, kindergarten, elementary school, secondary school through grade 12, or college or university. **"School" does not include college or university courses of study which are offered off-campus, or are offered to non-traditional adult student, as defined by the governing board of the institution, or are offered at colleges or universities which do not have residence hall facilities.**

## **Effective July 1, 1991:**

I. Haemophilus influenzae type b (Hib) vaccine: The minimum number of doses required by age group is:

- 0 for children < 2 months
- 1 for children 2-3 months
- 2 for children 4-14 months
- 1 for children 15 mo.- 4 years
- 0 for children > 5 years

II. A disease history for measles, mumps or rubella is not acceptable for certification; however, written evidence of a laboratory test showing immunity is acceptable.

## **Effective July 1, 1992**

I. 7th graders and college freshmen who were born since January 1, 1957 must have had two measles doses, **two mumps doses and two rubella doses; if the student received a second measles dose prior to July 1, 1992, the second rubella and mumps dose are not required.** The measles, mumps, and rubella doses must have been administered on or after the first birthday, and at least one month apart. By July 1, 1995 all college students born since January 1, 1957 must comply. By July 1, 1997 all students in grades 7-12 must comply.

II. One dose of MMR (measles, mumps and rubella vaccine) must have been administered at age 15 months or older to be acceptable for certification for students who enroll for the first time in a nursery school, day care center, child care facility, family care home or school grade K-12.

The Supplement to the DTP pamphlet which contains information on the DTaP vaccine will be sent to physicians who have previously received immunization forms from us.

For further information contact Nedra Freeman at the Colorado Department of Health, (303)331-8323 or Lynn Livingston at CMS, (303)779-5455 or 1-800-654-5653.

<sup>1</sup>US Department Of Health And Human Services, Public Health Service, Centers for Disease Control. *Supplement to the pamphlet, Diphtheria, Tetanus, and Pertussis: What You Need to Know.* 1991.

*"The most current school entry immunization requirements"*

# Medical Training In Costa Rica

by Gil Maestas II

(Material provided by military public affairs staff in Latin America)

*"It's not often you get an opportunity to give so much of yourself to someone in need."*

Col. Thomas Canfield M.D.



CMS File Photo

Col. Thomas Canfield M.D.  
Commander,  
147th Combat Support Hospital  
Colorado Army National Guard

Over the past two years, U.S. involvement in the Middle East and Latin American countries has increased. With this involvement, regardless of war or peacetime activities, many opportunities for hands-on medical training have become available.

Military exercises in Latin America are important to all Americans and to the people of Colorado in particular. Recently, members of the 147th Combat Support Hospital, Colorado Army National Guard, traveled from Aurora, Colorado by land, sea and air to take the "Help Wanted" sign out of Costa Rica's window. Their arrival in Golfito, Costa Rica began two-weeks annual training and marked the beginning of a *Medical Readiness Training Exercise* or MEDRETE.

MEDRETE is becoming a well-known term throughout Central and South America as more and more U.S. National Guard and Reserve members are sent there to train and work. MEDRETE involves three areas: medical, veterinary and dental. Due to transportation problems (such as no automobiles or roads), many Costa Ricans can't get to locations where medical care is available. Costa Rican physicians are only able to visit these remote communities about twice a year. Medical care provided by the United States government and the 147th Combat Support Hospital is available at no cost to the residents. It is estimated that they will treat over 8,000 patients and 4,000 animals.

The MEDRETE program is a

joint-nation assistance project in cooperation with the Costa Rican Ministry of Health. Similar exercises have been held in several other Central and South American countries such as Belize, Bolivia and Guatemala. This type of program gives our military men and women unique hands-on work experience that isn't readily available in the United States, and it often results in the human interest aspect of vastly improving the lives of the people who live there.

Col. Thomas Canfield M.D., 147th commander and Colorado Medical Society member, said he and unit members were thrilled to be in Costa Rica. "Just knowing that we are helping people to feel better makes me happy," he said with a smile. "It's not often you get an opportunity to give so much of yourself to someone in need. And there is definitely a need here," Canfield said.



Capt. David Hendrick, MD, of Denver examining a patient in Costa Rica field support hospital exercise.



# Colorado National Guard Doctors in Latin America

Colorado Army National Guard Capt. David Hendrick also took part in training with the 147th Combat Support Hospital. Capt. Hendrick is a surgery resident at St. Joseph's Hospital in Denver. During this training period he worked in the small village of Drake, located near Golfito, Costa Rica. Due to the remoteness of the area, members of the 147th were flown to the site by helicopter. Costa Rican citizens traveled by horseback or foot to arrive at a local school, which had temporarily been converted into a hospital. "It is obvious that the message about our mission here spreads quickly by word of mouth," said Hendrick. "These people are very proud and seem to have a lot of religious values. Most had to travel several miles in the heat, over mountains and through valleys, but they still wore their Sunday best here."

Hendrick was primarily involved in the medical division where he treated many common illnesses such as fungal infections, parasites and pin worms. "In the United States you rarely see such a wide variety of infections, which appear to be common here. However, it didn't affect our ability to treat the problems. We have a lot of talented people in our unit." Dr. Hendrick claims the free services they provided will make for his most memorable annual training. "I don't think anyone back in the states can begin to imagine what type of situation these people live under. If they did, I'm positive they would volunteer

right and left to help," he said. "The National Guard should be given a lot of credit for participating in this type of exercise."



*Capt. David Hendrick, MD (right), from Denver's St. Joseph's Hospital, examines a patient during a Medical Readiness Training Exercise near Drake, a small hamlet near Golfito, Costa Rica. Staff Sgt. Dean Farrar, a practical nurse from Montrose, Colorado, assists. Both are members of the 147th Combat Support Hospital, Colorado Army National Guard.*

Costa Rica photos by Sgt. Ron Pettus, 147th Public Affairs Detachment



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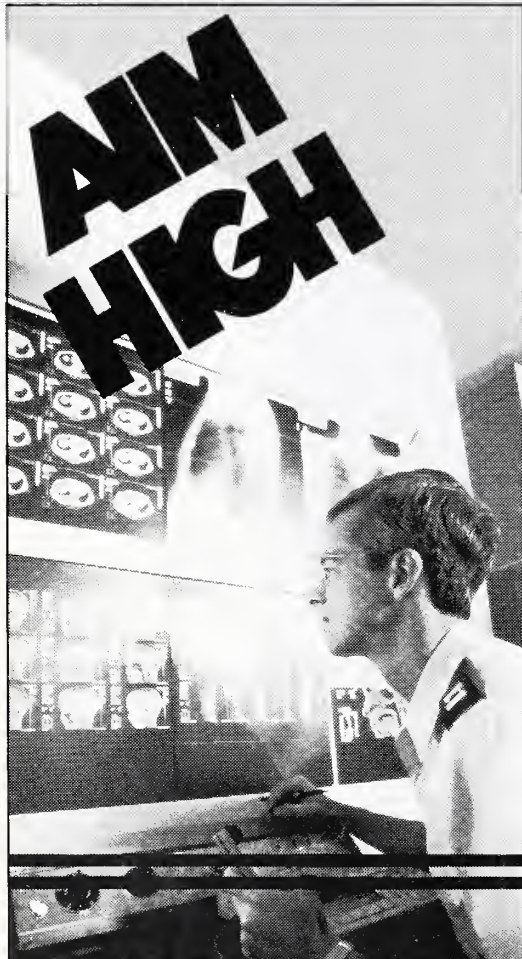
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# COMPAC WINS!

During 1990, the Colorado Medical Political Action Committee enjoyed a success rate for COMPAC support and contributions totaling 84%.

This figure includes only candidates *with* opposition.

Representative Dan Prinster (D) from Mesa County, is a recipient of COMPAC support. Dan expressed his feelings on PAC support in a recent telephone interview with CMS. He stated "COMPAC support has opened my eyes to a variety of different issues. The money is helpful but the support by word of mouth is also very important. The medical community doesn't always support my stand on various issues, but through COMPAC it has opened doors and developed a rapport with physicians to at least listen to what I have to say. COMPAC is valuable, it not only shows support from the medical community, but it's also an important component of the legislative process".

COMPAC recommended that the American Medical Political Action Committee (AMPAC) provide \$53,000 to Colorado Congressional Candidates. The recommendations were accepted and the funds were disbursed.

In 1990 there was a total of 82 legislative races. The Colorado Political Action Committee stayed out of eight races, but contributed to 74 of these races. With a total of 74 candidates running, 16 were unopposed. Funds were sent to assist these candidates in communications with their constituents.

COMPAC continues to successfully represent the voice of Colorado physicians in the legislative arena.

Let your voice be heard! For more information contact; Department of Government Relations, Colorado Medical Society. (303) 779-5455.

# Americans With Disabilities Act:

by Sandra D. Burns

ADA Coordinator Colorado Department of Social Services

**Note:** The State of Colorado has no enforcement authority in relation to the Americans with Disabilities Act. The information in this article is offered as guidance and to stimulate thought by presenting some relevant examples. It should not be relied upon in lieu of an interpretation by a qualified legal advisor.

**Background** - Since it was signed into law on July 26, 1990, the Americans with Disabilities Act (ADA) has been the subject of numerous articles, some explaining its provisions and others speculating about its impact. This article is intended to address issues that could come up in the treatment of patients. It is intended to assist physicians in complying with the law, by recommending steps to take in meeting the new requirements.

**Purpose of ADA** - The ADA is a civil rights law. Its intent is to eliminate discrimination by promoting attitudinal changes. Under the ADA, the guiding principles to consider relative to the needs of Individuals with disabilities are equal opportunity to participate, equal opportunity to benefit, and receipt of benefits in the most integrated setting appropriate.<sup>1</sup> Persons with disabilities are entitled to the "full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any public accommodation. . . ."<sup>2</sup> The ADA does not guarantee that an individual with a disability must achieve an identical result or level of achievement as persons without disabilities.<sup>3</sup> Under Title III of the ADA, businesses open to the public, including the professional offices of physicians and other medical service providers, have several obligations. Steps can be taken in advance, to be prepared for these obligations and head off the possibility of a complaint.

1. Do an assessment of your physical facility for architectural barriers and remove them if it is readily achievable to do so.<sup>4</sup> Although a self-evaluation is not required of public accommodations, it can diminish the threat of litigation and save resources by identifying the most efficient means of providing required access.<sup>5</sup> A useful tool in reviewing your facility for accessibility is the *Existing Facilities Checklist*. It is available, at no cost, through the ADA Technical Assistance Center in Colorado Springs. Once you have

identified any architectural barriers, you need to determine which ones it is "readily achievable" to remove. The "readily achievable" standard is defined as "easily accomplishable, able to be carried out without significant difficulty or expense".<sup>6</sup> If your offices occupy leased space, you and your landlord each have full responsibility for assuring that the facility is accessible, unless the lease agreement defines the responsibility in some other way.<sup>7</sup> Tax incentives may be available to you for removing architectural barriers. Check with your accountant or obtain IRS Publication 907 for further guidance. You have a continuing obligation to remove barriers, as it becomes "readily achievable" to do so.<sup>8</sup> Therefore, if all barriers cannot be removed at once, it is advisable to develop a plan for removing them over time.<sup>9</sup>

2. Identify alternatives to barrier removal. If it is not readily achievable to remove all the physical barriers immediately, you must use other means to make your services available, if such means are readily achievable.<sup>10</sup> An example of an alternative to barrier removal is to arrange with a colleague with offices in the same building to make an accessible examination room available when you need to examine a patient that cannot be accommodated in your offices. Explain any such arrangements to your staff, so that they will not inadvertently discriminate against an individual with a disability who calls for an appointment and cannot be accom-



# Steps Toward Compliance

modated in your offices.

3. Be prepared to make written materials available in alternate formats or to provide someone to read them aloud. Under the ADA, individuals with blindness or visual impairments may ask that written materials be made available in an alternate format (tape recorded, large print, braille). If this is not available, staff may read the material to them.<sup>11</sup> Individuals may also ask for assistance in completing medical history or insurance forms. Establish a policy for your office staff so that they know it is their obligation to provide these services. If you regularly provide informational materials in writing to your patients, you may wish to have tape recorded or large print copies made in advance. Various volunteer organizations, including the American Red Cross, will do tape recording. Large print can be produced on most word processors and on some copy machines. The number of braille readers is not large. However, if you receive a request for braille, several organizations offering braille transcription services are the Boulder Public Library or the American Red Cross. The cost ranges from ten cents per page to several dollars per page.

4. Be sure your office staff has a list available of qualified interpreters for individuals who are deaf. Under the ADA, "Qualified interpreter means an interpreter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary".<sup>12</sup> Inter-

preters are usually required for complicated consultations, such as discussions of impending surgery or explanation of a medical diagnosis of conditions. For less complex interactions, lip reading, note writing, or taking turns typing on a computer console may be sufficient. You can generally rely on your patient to make his/her preferences known. However, you may make the decision of what service to provide, as long as the method chosen results in effective communication.<sup>13</sup> Contact your local Center on Deafness, your local office of Colorado Rehabilitation Services, or the Interpreter Training Program at Front Range Community College to obtain the names of qualified interpreters. The cost for all interpreter generally ranges between \$20 and \$40 per hour.

5. Be sure staff know how to use **Relay Colorado** to communicate with individuals who are unable to use a regular telephone. **Relay Colorado** is a service which allows someone who uses a text telephone, or TT, (formerly called a telecommunications device for the deaf, or TDD) to speak with someone who communicates by voice. The Relay operator has a text telephone and serves as the intermediary between the two parties, reading aloud what the TT user types and typing into the TT whatever the voice caller says. This service can be used by anyone who cannot use a regular telephone, whether the condition is temporary or permanent. Laryngectomy patients or patients who have undergone

## About the author:

*SANDRA BURNS' professional career spans over twenty years. During that time, she has worked with economically disadvantaged workers, as well as persons with disabilities. She has been with Colorado Rehabilitation Services in a variety of capacities; as a counselor with persons with blindness or visual impairments, supervising a unit serving persons with psychiatric disabilities, and as Director of a program providing rehabilitation to individuals receiving Worker's Compensation. Her current assignment is as Coordinator of the Americans with Disabilities Act for the Department of Social Services. In that capacity, she is taking a leadership role in coordinating the implementation of the requirements of the ADA in all state agencies. Sandra has a bachelor's degree in Journalism from the University of Colorado at Boulder and a master's degree in Guidance and Counseling from the University of Colorado at Denver.*

*"...accommodate the needs of individuals with disabilities and convey to your staff the need to comply with the law."*

*(Continued from pg. 271)*

surgery to their jaws could also benefit from its use. Your office does not need to have a text telephone on site, unless you allow patients to make calls on more than an incidental basis.<sup>14</sup> For those incidental situations such as calling a taxi, staff can provide the needed assistance.

6. Make sure materials provided in an audio or video format are usable by persons with deafness or hearing impairments. Some drug companies offer informational or instructional materials in videotaped formats.

Contact the company and request that they provide copies that are captioned for patients with deafness or hearing impairment. Any materials you offer in a videotape or audiotape format should also be available in print.

7. Consider in advance how you will handle a service animal accompanying an individual with a disability. "Service animals include any animal individually trained to do work or perform tasks for the benefit of an individual with a disability. Tasks typically performed by service animals include guiding people with impaired vision, alerting individuals with impaired hearing to the presence of intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or retrieving dropped items."<sup>15</sup> A service animal must be allowed to accompany its owner, unless it poses a direct threat to health or safety. The regulations do not require a public accommodation to supervise or care for a service animal.<sup>16</sup> If there are situations in which the animal would pose a direct threat to the health or safety of others or could be at risk itself, such as during an X-ray examination, it is the responsibility of the individual with a disability to arrange for the care and supervision of the animal.<sup>17</sup>

#### **Surcharges**

Although provision of some services may result in some additional costs, you may not place a surcharge only on particular individuals with disabilities or groups of individuals with disabilities to cover these expenses.<sup>18</sup>

#### **Conclusion**

These are intended to be examples of accommodations that may need to be made for individuals with disabilities. They may not all be necessary or applicable to your setting. Likewise, you may receive requests that are not covered here. The most important point is that you give some thought in advance to the need to accommodate the needs of individuals with disabilities and convey to your staff the need to comply with the law. An insensitive statement by yourself or a member of your staff could result in an individual with a disability taking action, either by filing a complaint with the Department of Justice or by filing a civil action.

#### **References:**

1. *The Americans with Disabilities Act Title III Technical Assistance Manual*, U. S. Department of Justice, Civil Rights Division, Office on the Americans with Disabilities Act, page 13.
2. *Americans with Disabilities Act Handbook*, published by the Equal Employment Opportunity Commission and the U.S. Department of Justice, October 1991, United States Government Printing Office #EEOC-BK-19, page III-41.
3. *Op Cit.*, *Title III Technical Assistance Manual*, page 13.
4. *Op Cit.*, *Americans with Disabilities Handbook*, page III-85.
5. *Op Cit.*, *Title III Technical Assistance Manual*, page 34.
6. *Op Cit.*, *Americans with Disabilities Handbook*, page 111-85.
7. *Ibid.*, page III-37.
8. *Op Cit.*, *Title III Technical Assistance Manual*, page 33.
9. *Ibid.*, page 37.
10. *Ibid.*, page 37.
11. *Ibid.*, page 26.
12. *Op Cit.*, *The Americans with Disabilities Handbook*, page III-34.
13. *Op Cit.*, *Op Cit.*, *Title III Technical Assistance Manual*, page 26.
14. *Op Cit.*, *The Americans with Disabilities Handbook*, page III-79.
15. *Op Cit.*, *Title III Technical Assistance Manual*, page 23.
16. *Op Cit.*, *Americans with Disabilities Handbook*, page III-75.
17. *Ibid.*, page III-77.
18. *Op Cit.*, *Title III Technical Assistance Manual*, page 22.



# Americans with Disabilities Act Resource Directory Information and Resources

Meeting the Challenge, Inc. 3630 Sinton Road  
Colorado Springs, CO (800) 949-4232 Contact:  
Patrick Going or Randy Dipner (can provide written  
information, including the *Checklist for Existing  
Facilities*, and maintains a computerized listing of  
available resources).

Disability Information and Referral Service (DIRS)  
Rocky Mountain Resource and Training Institute 6355  
Ward Road, #310 Denver, CO 80214. (303) 420-  
2942

Assistive Technology Project  
Rocky Mountain Resource and Training Institute  
6355 Ward Road, #310 Denver, Co 80214 (303) 420-  
2942  
Contact: Bill West

Your local Independent Living Center  
Check your local telephone directory or call Colorado  
Rehabilitation Services for complete list (303) 866-  
5196

## INTERPRETERS FOR THE DEAF

Center on Deafness  
1900 Grant St. Denver, CO 80203  
(303) 539-8022  
Contact: Mourine Tessler  
(also offers a service to add captioning to videotapes)

Northern Colorado Center on Deafness  
800 8th Avenue, Suite 323  
Greeley, CO 50203 (303) 352-8682  
Contact: Cheryl Lewis-Martinez

Pikes Peak Center on Deafness  
2133 N. Academy  
Colorado Springs, CO  
(719) 591-2777

Front Range Community College  
3645 W 112th Avenue Westminster, CO 80030  
(303) 466-8811 Interpreter Training Program  
Contact: Elaine Woody

Local School District Special Education Offices

## BRAILLE OR RECORDING FOR THE BLIND

American Red Cross  
170 Steele  
Denver, CO 80206  
(303) 399-0550

Boulder Public Library  
1000 Canyon  
Boulder, CO 80303  
(303) 441-3098

State Library for the Blind  
180 Sheridan Blvd.  
Denver, CO 80226  
(303) 727-9277

Colorado Rehabilitation Services  
Rehabilitation Center  
2211 W. Evans Ave.  
Denver CO  
(303) 937-1226  
Contact: Candy Leathers

## GUIDANCE FOR MEDICAL PROVIDERS

National Rehabilitation Hospital  
Health Care Facility Access Project  
102 Irving Street, NW  
Washington, D.C. 20010  
(202) 877-1974

President's Committee on Employment of Persons  
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Medical Concerns Subcommittee  
1331 F Street, NW  
Washington, D. C. 20004-1107  
Contact: Ruth Ellen Ross

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# Non-Physician Medical Care

Mary Jean Berg, MD, Chair  
Council on Medical Service

*"Current regulations and statutes do not adequately define the relationships between the supervising physician and the non-physician medical provider."*

The Council on Medical Service has devoted considerable time and effort over two years to learn how non-physicians (specifically physician assistants and nurses in expanded roles) are utilized in the delivery of medical care. This effort was prompted by a concern that, while rural areas in the state would benefit from the medical services of non-physicians, these providers have practiced medicine in a maze of rules, regulations, customs, and supervision which is lacking in consistency, clarity, and oversight. It has become clear during our evaluation that these identified problems are not limited to rural non-physician medical providers, but are statewide problems.

Current regulations and statutes do not adequately define the relationships between the supervising physician and the non-physician medical provider. The scope of practice is not clearly defined for both physician assistants and nurses in expanded roles. Guidelines for the formulation and review of protocols are not utilized. There is no single oversight body or agency

charged with the specific responsibility of monitoring physician/non-physician medical provider relationships. There exist federal rules and regulations which are inconsistent with state regulations regarding the manner in which non-physician medical providers practice. These problems and others make it incumbent on organized medicine to take a leadership role in the development and implementation of clear guidelines for the delivery of medical care by non-physicians in the state.

The Council strongly believes that the following resolution on Non-Physician Medical Practice is a critical first step toward correcting the problems that exist in the utilization of non-physicians to provide medical care in Colorado. The state lags far behind most states in effectively managing non-physician medical practice. The Council asks the CMS membership to become informed about this issue, and to carefully consider the importance of providing leadership to correct identified problems. The Council asks for your assistance in moving this resolution through the process of adoption and implementation.



## Colorado Medical Society

Introduced by: Council on Medical Service

Subject: Non-Physician Medical Providers in Colorado

Referred to: Reference Committee on Community Health Issues/Medical Service

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WHEREAS, non-physicians provide medical care under a variety of statutes, rules and regulations in Colorado, and

WHEREAS, the education and training of non-physician medical providers varies, as does their allowable scope of practice and their requirements for physician supervision, and

WHEREAS, non-physician medical providers should be supervised by physicians, and

WHEREAS, there is currently no comprehensive mechanism for defining, registering, or monitoring non-physician medical practice provided in conjunction with a licensed physician, and

WHEREAS, physicians have a responsibility to assure oversight of medical care delivered by non-physician providers, therefore be it

RESOLVED, that representatives of the Colorado Medical Society meet with the Boards of Medical Examiners and Nursing to develop comprehensive guidelines for the oversight of all non-physician medical providers in Colorado. Such guidelines should include the following concepts:

- 1) All physicians licensed in Colorado associated in a supervisory relationship with non-physician medical providers (physician assistants or registered nurses in expanded roles) should register with the Board of Medical Examiners their name, address and the address(s) of all non-physician medical providers for whom they provide supervision. All changes in such supervisory relationships should be sent to the Board at the time of their occurrence.
- 2) All physicians who supervise non-physician medical providers should periodically provide evidence to the Board of the total number of non-physician medical providers supervised, the extent of on-site supervision and the extent of review of patient care. The physician should be on-site a minimum of once per week.
- 3) No physician should supervise a non-physician medical provider whose scope of practice is different than his/her own.
- 4) No physician should supervise a non-physician medical provider outside the geographic area in which the physician regularly practices.
- 5) Written practice agreements between the physician and the non-physician medical provider should accompany the physician's registration and identify 1) the settings within which the non-physician medical provider is authorized to practice, 2) the agreed scope of practice of the non-physician medical provider, consistent with the Colorado Medical and Nurse Practice Acts, and 3) the quality assurance program to be utilized, including the network of medical care into which the non-physician medical provider is connected should the supervising physician be unavailable or a greater level of care be required, and 4) the medical protocols to be utilized by the non-physician medical provider, and be it further

RESOLVED, that the Colorado Medical Society should encourage and support the Boards of Medical Examiners and Nursing in the pursuit of rules and regulations for expanded or advanced nursing practice, with the development of a conjoint Board which would oversee non-physician medical practice in this state.

FISCAL IMPACT:None



Edie K. Register, Director  
Health Care Financing Department

# More on E&M Codes

Grant Steffen, MD  
Medical Director, Medicare Part B  
Blue Cross/Blue Shield of Colorado, Inc.

*"First, at what intensity levels were the history, exam, and decision making? Second, from which family of E/M codes do you select the code?"*

On June 9, I received a 37 page document from HCFA headquarters that contained updates on several important policies concerning the Evaluation and Management (E/M) codes. I want to share some of these with you because they may either clarify some unclear policies or indicate a significant change in policy.

There are two questions you need to answer when choosing the right E/M code. First, at what intensity levels were the history, exam, and decision making? Second, from which family of E/M codes do you select the code; e.g. a consultation code or an initial hospital visit? The first question is certainly the most difficult just because the definitions in the CPT manual do not always help to discriminate between neighboring codes. HCFA has made this clarification for a comprehensive history.

"The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to update the existing record, to reflect only changes in the patient's medical family and social history from the last encounter." Implied but not

mentioned in this paragraph is the obvious need to note the chief complaint and an extended history of the present illness.

Note that this description of a comprehensive history makes no mention of a single system specialist's history. For the generalist or the specialist, a comprehensive history must include the elements listed above.

HCFA did not clarify what for me is a more problematic issue, a way to distinguish between the four levels of an exam. Note that a detailed exam carries the motion of an "extended examination," but CPT fails to define extended. Except for that word, the description of an expanded problem focused exam is very similar to that for the detailed exam.

Here's how I sort these levels out. The problem focused exam involves one system or area, e.g. an exam for a patient with a sore throat. A complete exam involves the entire body and, depending on how you count, ten or so systems or areas. I consider a comprehensive exam to include most of those systems or areas, eight or so, but not necessarily all since the clinical situation may prevent your doing a complete exam.





An expanded problem focused exam involves two and perhaps three areas or systems and a detailed exam involves five (plus or minus) systems or areas. This rough separation of the four levels of exam is justified in part by the progression of the work elements of the relative value units assigned to the visit codes. For example, the established patient office codes 99212 through 99215 have a work RVU spread of 1.06 and 99214 (requiring a detailed exam) has a work RVU .53 above 99212 and .53 below 99215. Because the detailed exam is placed midway between the minimal (problem focused) exam and the comprehensive exam, I believe that it is reasonable to expect a detailed exam to include about half of the comprehensive exam.

I apologize for this complex analysis of a problem area, but don't know any way to avoid complexity when analyzing an inherently complex and infinitely variable event, the physical exam.

To add to this complexity, the comprehensive exam includes, in addition to a complete multi-system exam, a complete single system specialty exam. I don't know what this means! The AMA, creator of the CPT and its definitions, does not offer what seems logically necessary,

namely a problem focused single system specialty exam, an expanded problem focused single system specialty exam, and a detailed single system specialty exam. If any of you have recommendations on how to sort out four levels of a single system specialty exam, please share them with me.

For those of you who do critical care, the following change of policy should be welcome. The CPT definition of critical care "bundles" together many procedures that have their own CPT number, e.g. thoracostomy and intubation. HCFA now recognizes that the RVUs assigned to the two critical care codes 99291 and 99292 were too low and have accordingly unbundled some of the procedures from the critical care services. Still included in the critical care codes are venipuncture, arterial puncture, chest x-rays, temporary transcutaneous pacing, cardiac output measurements, ventilator care and pulse oximetry. Excluded are tube thoracostomy, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, endotracheal intubation, and other procedures not mentioned above.

Next month I will discuss some of the issues that surround the admission H&P as well as some global surgical policy clarifications.

*"If any of you have recommendations on how to sort out four levels of a single system specialty exam, please share them with me."*

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**Subjective:** "The Plaintiff's husband had his first embolism 21 months ago."

**Objective:** "Doctor, please show the *court* that record in your chart."

**Assessment:** "Oh ... #@\$#@\* ...  
..... I can't find it!"

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# Abraham Lincoln: Malpractice Defense Attorney

by Gwilym B. Lewis, MD

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## The "chicken bones case,"

During his twenty-five years of law practice in Illinois, Abraham Lincoln's reputation was primarily as an attorney for the defense. His retention by the Illinois Central Railroad as one of their chief counsels and his successful defense of many murder cases are well-known to Lincoln buffs.

Then as now, 19th century America, particularly in rural and pioneer areas, was remarkably litigious. Suits against physicians were common; A case defended by Lincoln, known to legal historians as the "chicken bones case," has been documented.

On October 16, 1855, one Samuel Fleming was a curious onlooker at a livery stable fire in Bloomington, Illinois. He was struck by a falling chimney, breaking both legs. The fractures were treated by setting and by the application of splints by Drs. Rogers and Crothers of Bloomington. The right leg healed with angulation and shortening. The doctors recommended refracturing and resetting the leg. This was attempted, using chloroform anesthesia. The patient awakened during the procedure in great pain and demanded that the operation be terminated. He stated that he would prefer his disability to enduring further suffering. The doctors urged him to go through with the procedure but the patient was adamant. Months later he could walk, but the bones were permanently malunited.

He hired a team of lawyers who,

on March 28, 1856, filed suit of malpractice against Drs. Crothers and Rogers in the McClean Circuit Court alleging the defendants "not regarding their said duty but intending and contriving to injure said plaintiff did not use due and proper care, skill or diligence." The defendants engaged four Bloomington lawyers who then brought in Lincoln of Springfield to bear the main weight of the argument.

In the course of the trial Lincoln used pliant bones from young pullets and hard brittle bones from chickens to demonstrate to the jury, problems of fracture healing in older people.

In his cross examination of the plaintiff Lincoln said: "Well! What I advise you to do is to get down on your knees and thank your Heavenly Father, and also these two doctors that you have any legs to stand on at all."

The trial was protracted. After eighteen hours deliberation, the jury was deadlocked. The case was put over to the next court term. After further postponements, on March 15, 1858, the case was dismissed by agreement of the parties.

As we reflect on the honor of our past presidents this February, it is perhaps of some consolation to our beleaguered profession to know that our most esteemed President would probably be on our side.

Reference: Duff, John "A. Lincoln, Prairie Lawyer" Bramwell House (1960): 327-329.

*"...our most esteemed President would probably be on our side."*





*A monthly report of current and on-going activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

August, 1992

## **New Family Health and Safety Committee**

The **COMMUNITY HEALTH ISSUES COUNCIL** has recently created a new committee that is charged with addressing the issues of maternal and child health, reproductive health, injury prevention and geriatric care.

Dr. William Miller has agreed to co-chair this committee and another co-chair is being sought. Initially this committee will meet on Wednesdays at 6 pm.

If you are interested in being a member of this committee or would like to act as co-chair, please contact Marilyn Barton at CMS.

## **New Advance Directive Booklet**

As a result of actions by the legislature it has become necessary to revise the booklet *Your Right to Make Health Care Decisions*. This new law puts into statute what has been accepted practice in regard to medical durable powers of attorney and living wills.

The new booklet should be available by early fall. Until that time you or your patients may continue to use the original booklet. Copies are still available by calling CMS offices.

## **Medical Informatics**

The **MEDICAL INFORMATICS COMMITTEE** of the Colorado Medical Society has recently endorsed the workshop Medical Office Computing, sponsored by the University of Colorado School of Medicine's Office of Continuing Medical Education. The third in a series of hands-on workshops on medical computing, this newly expanded program will take place in Aspen September 18-20, followed by optional, focused workshops September 21, 22, 1992.

The workshop will provide instruction in the general use of the computer, and in its use in the clinical setting. Issues to be addressed include the hardware and software available today and its appropriateness in the home and office. The program is designed to accommodate all levels, from those with no experience to those well versed in the use of the computer. Call Joann Bauer at the University, 1-800-882-9153 or (303) 270-5195 for more details.

**PAPERCHASE** is a new service offered by the Denver Medical Library for access to Medline, the world's largest biomedical database. Physicians may access the service from any computer with a modem, define search parameters and obtain medical information 24 hours per day, any day of the year. Estimate subscription cost will be \$150. Contact the Denver Medical Library at 839-6670 for more information.

The American College of Cardiology **COMPUTER APPLICATIONS COMMITTEE** is accepting abstracts of computer programs for possible presentation at its 42nd Annual Scientific Session March 14-18, 1993 in Anaheim, Calif. Deadline for submissions is September 9, 1992. Contact the Committee at 1-800-257-4738 for more details. The ACC also publishes the *Cardiovascular Software Directory on Disk*. Call 1-800-253-4636 for a copy.

The **UNIVERSITY OF DENVER** has designed a new certificate program called Healthcare Information Systems. The program is targeted toward health care managers who need additional computer training to meet the needs of the day in relying on computer-based information to make decisions. Call University College at 871-3155 for more information.



## HIGHLIGHTS OF THE BOARD OF DIRECTORS MEETING, MAY 22, 1992

- CMSA** Mrs. Pam Laman, newly installed President of the Colorado Medical Society Auxiliary, indicated that her theme for this year would be "Partnership", emphasizing the partnership between the county, state and national levels as well as with spouses.
- AMA Delegation** Dr. Ray Painter reported on the resolutions being taken to the AMA Annual Meeting in Chicago in June. The resolutions are dealing with the Americans with Disabilities Act, Physician Payment Reform, AMA Unified Voice for All Physicians, Waste Management/ OSHA regulations and the Patient's Right to Know issues.
- Executive Committee** The Board ratified the actions of the Executive Committee which directed CMS Staff to develop a policy on membership parameters for all CMS Councils and Committees. Also, agreed to assist the Colorado Rural Health Scholars Program with a contribution.
- Finance Committee** The Board ratified the actions of the Finance Committee in approving a change in the current investment management for CMS and approved a request for financial support to help produce a training video for hospital staff in dealing with victims of spousal and elder abuse.
- Resolutions from IM '92** The Board took the following actions on the Resolutions referred for action.  
RES-14, changes to the Community Health Issues Section of the Policy Manual, was referred to the Council on Community Health Issues for clarification.  
RES-15, membership in COMPAC/AMPAC, is considered complete.  
RES-27, publishing a Pro-active newsletter for patients, was considered as not a reasonable activity at this time, although the Board agrees with the concept of improving the image of the medical profession.

## HIGHLIGHTS OF BOARD OF DIRECTORS MEETING ON July 24, 1992

- Executive Committee** Dr. Leigh Truitt introduced representatives from the Chase Manhattan Investment Services, Inc. who presented a brief outline of services available for CMS members.
- CMS Auxiliary** Mrs. Pam Laman, President, reported on actions taken at the AMAA Annual Meeting where Mrs. Mary Hanson, CMSA member, was installed as President-Elect.
- AMA Delegation** Dr. Richert Quinn reported that the five resolutions submitted by the Colorado Medical Society to the AMA House of Delegates were adopted. In addition, Dr. Quinn reported that Dr. Robert Bogin had been elected to the AMPAC Board of Directors, a position of considerable influence.  
  
Dr. Quinn announced that he will be seeking a seat on the AMA Council on Constitution & Bylaws.
- UC School of Medicine** Dr. Richard Krugman, Dean, was present and reported to the Board on the future plans and goals for the School of Medicine.
- Finance** The Fiscal 1993 Budget was approved.
- Action Items** The Board approved a Locum Tenens proposal from the Council on Medical Service in which CMS would act as a matching service. Details will be published at a later date. The Board approved the establishment of a yearly cash award to be given to the graduating medical student who demonstrated leadership qualities. The award will be given in accordance with guidelines developed by the Medical Student Component.  
  
The Board approved several resolutions which will be presented to the House of Delegates in September.

## EMERGENCY MEDICINE

**Fort Carson** - Three civilian ED positions for 126-bed military hospital. Annual ED volume of 45,000. Located at the foot of Pikes Peak, 20 miles south of Colorado Springs. Physicians need to be BC/BE in primary care or pediatrics.

**Fort Morgan** - ED staff opportunity available at this small community hospital. Located in northeastern Colorado, this 40-bed facility has an annual volume of 4,000. Fort Morgan is 75 miles northeast of Denver.

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## Thanks Go To Physicians Who Served As Special Judges at Successful '92 Colorado State Science Fair

Nearly 400 middle- and high-school students participated in the April 9-11 Fair. Of these, more than 25 entries were judged under the medical science criteria. The winners, Warren Gasper of Fort Collins and Diann E. Miyake of Englewood.

Three special judges for Colorado Medical Society were **Drs. James Regan of Denver, Thomas Flower of Greeley and Russell Bobo of Fort Collins.**

Drs. Regan and Flower are CMS members. Dr. Regan is the Chairman of the Young Physician Section. Dr. Flower has been active since its inception in the CMS Correctional (Jail) Health Care Program. Dr. Bobo is an Anesthesiologist.

Winners of the Junior and Senior Divisions in the medical sciences competition will display their exhibits at the CMS Annual Meeting in September at Copper Mountain. Each winner will receive a \$100 US Savings Bond.

Drs. Regan, Flower and Bobo interviewed each of the contestants. Each contestant is interviewed about the experiment exhibit as the judges base their decisions on both the personal knowledge of the entrant as well as the physical exhibit.

One of the Colorado State Science Fair pioneers, **Dr. H. Calvin Fisher (Ret) of Colorado Springs** was on hand as well. The special judging was an excellent opportunity to bring these physicians together, all of whom have special interests in promoting the natural sciences in our schools at an early age. Dr. Regan, in recent years, has been promoting the CMS "Natural Science Ambassador" program, finding physicians to become classroom ambassadors for natural science studies in grade school and up. Dr. Fisher continues to urge CMS members to play a major role in the Science Fair which, he says, forms an excellent relationship with this important sector of the patient/public.

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## 1992 Series

### Copic Lawsuit Stress Rap Sessions

For those who've experienced the personal ordeal which attends being named a defendant in a malpractice suit, here's an opportunity to explore that experience with peers and resource friends in a largely unstructured setting. All sessions: 7:00 - 9:30 pm with light refreshments

**PUEBLO** Thursday, August 13, 1992  
St. Mary Corwin Hospital, Minnequa Room

**AURORA** Tuesday, September 15, 1992  
Aurora Presbyterian Hospital, Oak Room

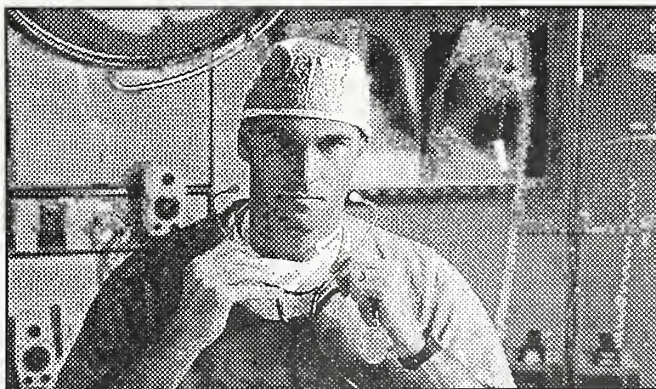
**BOULDER** Tuesday, September 22, 1992  
Boulder Country Club, Green Room

**COLORADO**  
**SPRINGS** Tuesday, October 6, 1992  
Cheyenne Mountain Conference Resort

**FORT COLLINS** Arrangements pending

If you plan to attend a session, please call Ms. Pat Schultz, Copic's Director of Marketing and Professional Relations, at (303) 779-0044 or (800) 421-1834, so that appropriate arrangements can be made for the session. The Lawsuit Stress Rap Sessions are being held in cooperation with the Pueblo County, Aurora-Adams County, Boulder County, El Paso County, and Larimer County Medical Societies.

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Concurrent with the new location, CPEP Executive Director Roxanna Fredrickson announced that Patrick Moran, M.D. and Richard H. Thompson Jr., M.D. will serve CPEP as co-medical directors. CPEP, formerly located in the Colorado Hospital Association building, is the collaborative effort of seven statewide organizations: Colorado Alliance for Continuing Medical Education, Colorado Foundation for Medical Care, Colorado Hospital Association, Colorado Medical Society, Colorado Physician Health Program, Colorado Society of Osteopathic Medicine, and the University of Colorado School of Medicine.

CPEP provides personalized assessment and education programs for physicians in their scientific knowledge, technical skills and interpersonal skills as they relate to the practice of medicine.

If you or a colleague is interested in assessment of your current medical practice or personalized training, please call CPEP.

### Trust Fund Awards Child-Abuse Prevention Grants

The Colorado Children's Trust Fund recently awarded \$200,721 to fund 15 Colorado agencies that offer child-abuse prevention programs.

Colorado State University's department of social work in the College of Applied Human Sciences administers the trust fund. It is supported by a \$10 surcharge on marriage license fees, federal grants and contributions.

The fund provides grants to Colorado organizations that deal with primary and secondary child-abuse prevention programs focused on strengthening families.

In Colorado, a record 29 children died during 1990 as a result of child abuse and neglect. Last year, 2.5 million cases of child abuse and neglect were reported nationally, and there were more than 1,200 confirmed fatalities due to abuse.

Joyce Jennings, program director for the Colorado Children's Trust Fund, says "Most of our programs are directed toward strengthening families before abuse and neglect occurs by reaching out to parents at the time of birth."

Agencies awarded one-year grants are:

Valley-Wide Health Services, the parent to five primary care clinics in the San Luis Valley.

Valley School District of Logan County  
Community Options of Montrose  
Developmental Opportunities of Fremont County

Family Visitor Program in Garfield, Eagle and Pitkin counties.

The Effective Parents Project of Mesa County  
The Rape Assistance and Awareness Program of Denver

Colorado Coalition for the Protection of Children  
Mental Health Center of Boulder

Arapahoe House (Healthy Options for Women program) in Denver.

Clear Creek County Youth Services

Tri-County Health Department

Summit County Youth and Family Services

Jefferson County Department of Health and Environment, and

Families and Friends of Convicts United for Support.



**Last week, the  
Arthritis Foundation  
helped Jennifer Adams  
get ready for  
a date.**







## Social Services "Band-Aids" Revenue Loss

The Colorado Department of Social Services (DSS) has made a partial attempt to remedy some of the revenue loss created by the passage of HB-1306, the Colorado Medical Assistance Act. After a large group of geriatric physicians informed the department that they would no longer accept new Medicare/Medicaid patients, the department considered that this would result in a "loss of access to primary medical care to these patients." It therefore agreed to pay three procedure codes at 100% of the Medicare rate through September 30, 1992.

DSS made this offer to allow "the Department, in consultation with [the geriatric group and its] physicians, the Colorado Medical Society and other interested parties to develop a long term solution that is consistent with the intent of HB 1306." However, CMS was not contacted in regard to this matter, nor were any other physicians outside the geriatric group, as far as we know.

HB-1306 mandated that DSS would pay *either* the Medicare *or* Medicaid amount on a particular procedure, whichever is *lower*, rather than both, as was previously done in cases where a patient was eligible for both. Since Medicare doesn't usually cover a physician's cost of providing services and Medicaid is often lower, it appears to be the intent of HB 1306 to significantly reduce the amount of reimbursement physicians will receive for services to Medicare/Medicaid

patients. The small Medicaid payment often acted as a "co-payment" in dual eligibility cases which helped the physician avoid a substantial loss on the service. It would appear that, in effect, the physician will be paid less for a patient with both Medicare and Medicaid than he or she would be paid for a patient who is only on Medicare.

Look for more information and an action plan in Med Fax with this issue.

## Smoke Free Dining

The Group to Alleviate Smoking Pollution (GASP) of Colorado has released its updated *Guide to Smoke-Free Dining in Colorado*, one of the most comprehensive directories of its kind in the country. The guide, free to the public, lists more than 300 restaurants in the state which are 100% smoke free.

Peter Bialick, president and founder of the Colorado chapter of GASP, said, "The number of smoke free restaurants in Colorado has tripled since our last guide was published in 1989. We see the trend toward more smoke free restaurants as a positive step toward the day when all restaurants are smoke free."

Since the EPA has classified environmental (second-hand) tobacco smoke (ETS) as a Class A carcinogen, this is a significant health problem. Class A substances are proven to cause cancer in humans. Exposure to ETS causes lung cancer, and heart disease, and is especially dangerous to children. Mr. Bialick says, "Separate smoking areas in restaurants do not provide adequate protections for the public. A

nonsmoking area can only be smoke free if it is completely enclosed and is independently ventilated.

For a copy of the guide, which covers five geographic regions in Colorado, call (303) 444-9799.

## Bogin Joins AMPAC Board

Robert M. Bogin, MD, former chair of the American Medical Association's Young Physicians Section, (AMA-YPS) has been appointed to the American Medical Political Action Committee board of directors. Dr. Bogin is a Denver Internist specializing in pulmonary diseases and has long been active in the Young Physicians Section and in representing Colorado on the national level.

Joy A. Maxey, MD, current chair of the AMA-YPS, said, "The appointment of this 35-year-old displays the continuing commitment of the AMA to mainstreaming young physicians." Congratulations, Dr. Bogin, from your colleagues in the CMS.

## New Mammography Equipment Guidelines

Since mammography is crucial to the early detection and treatment of the breast cancer that will strike one out of nine women in her lifetime, Bob Quillin, director of the Radiation Control Division at the Colorado Department of Health says new rules will help reduce unnecessary radiation exposure for women having mammograms and will also help improve their quality.

The new rules were issued by the Colorado Board of Health in response to consumer, health



professional, legislator and other concerns about the safety of mammography equipment and quality of mammography services in the wake of increased use of these services for screening and diagnosis, partly as a result of new laws requiring third party payors to provide coverage for some mammography services.

Director of the CDH Division of Prevention Programs, Walter "Snip" Young said the regulations are "a significant step forward in dealing with mammography equipment." He said the National Cancer Institute recommends that women seek a facility which performs at least ten mammograms per week with a dedicated mammography machine calibrated at least once a year, operated by a technician certified by the Registry of Radiological Technologists. They also advocated interpretation by a radiologist who is board certified and specifically trained in mammography.

For more information, contact the Radiation Control Division at the CDH, (303) 331-8407.

### Reportable Health Conditions

The Colorado Board of Health has issued list of health conditions which must be reported by law. They include many vaccine preventable diseases, contagious diseases, environmental, occupational and chronic conditions and other conditions which are of interest to public health officials. Call (303) 331-8330 for more information during daytime hours, (303) 370-9395 for after hours and weekend emergencies.

### Newborn Manual Available

Copies are still available of the Newborn Screening Practitioner's Manual (1990), published by the Mountain States Regional Genetic Services Network (MSRGSN).

The MSRGSN is a federally funded, multi-state forum created to enhance communication and utilization of services in the field of genetics.

Topics covered in the manual include Hypothyroidism, PKU, Galactosemia, Homocystinuria, MSUD, Cystic Fibrosis, Biotinidase Deficiency, Hemoglobinopathies, proper screening and follow-up practices, optimum timing of initial and confirmatory tests, how to obtain an adequate specimen, and the names, addresses, and telephone numbers of medical and laboratory consultants for assistance with follow-up of abnormal tests.

Copies may be obtained at no charge by contacting Joyce Hooker, (303) 331-8376.

### Advance Medical Directives

The American Medical Association (AMA) has published two companion booklets on Advance Medical Directives. Subtitled *A Guide to Living Wills and Powers of Attorney for Health Care*, one book is directed to physicians, the other to patients. The booklets deal not only with the issues surrounding medical directives, powers of attorney, living wills and the like, but also federal laws on the subject. They invite the reader to refer to specific state laws for more

information. Call the AMA for free single copies or ordering information at 1-800-621-8335.

### Diabetes Clinical Trials

Participants are needed to help the International Diabetes Center of Colorado research the effects of a new, more potent hypoglycemic agent. Volunteers will receive medical examinations, lab tests and EKG at no cost. Certain criteria must be met. Call Honora Caldwell, RN, MSN, at 425-2792 if you think any of your patients might qualify.

### Daniel Ellsberg to Keynote Conference

Daniel Ellsberg of "Pentagon Papers" fame will keynote a conference sponsored by Physicians for Social Responsibility (PSR) at Denver's Children's Hospital on September 26, 1992.

Ellsberg is a former State Department and Defense official who drafted the Kennedy administration nuclear war plans. Today, Mr. Ellsberg is director of **Manhattan Project II** at PSR, an anti-nuclear effort.

An additional lecture will be given by Dr. H. Jack Geiger. Dr. Geiger is a Logan Professor of Family Medicine, at City University of New York Medical School and is the principal author of *Dead Reckoning*, a critical review of the Department of Energy's epidemiologic studies on the health of workers at nuclear weapons plants.

For additional information call Jody Taylor, executive director, Physicians For Social Responsibility.





(def: to chew again what has been chewed slightly and swallowed; to REFLECT)

by **Bill Pierson**  
Managing Editor

## Where Health Care Reform Will Take Medicine: the destructive larva syndrome or the gallows theory

Given as I am to ruminating, I was wondering the other day about "health care reform" when it was last discussed with fervor in Washington and elsewhere. That was about ten years ago. In fact, in 1982, the Washington reform concept was taking on some pretty firm lines and a number of Capitol Hill luminaries thought they finally had the answer(s). But what has happened as a result of 1982 Washington reform? And what lessons should we have learned about massive health care reform?

Legislators and administration alike thought the reform answer was **deregulation** and **free market** or **increased competition**.

I asked Rachelle Kaye, Ph.D. (then Director of Program Planning and Evaluation, Colorado Foundation for Medical Care) to report on the meeting of legislators with the American Association of Foundations for Medical Care and the National Council of Hospitals. Her article was published in the March, 1982. (*"The Age of Competition in Health Care."* *Colo. Med.*, Vol 79, Number 3;113-115).

The article begins: "Discussions these days about health care 'on the hill' in Washington, D. C. are frequently punctuated with the current buzzwords 'competition' and 'consumer choice.'" The objective of the meeting was to discuss 'pro-competition' legislation for health care." In other words, the floodgates were about to open and we

were about to be pushed along by a wave which has since crested and is now petering out, sinking into the sandy beaches of time. It didn't work; the "buzzword" competition became a "buzzsaw," chopping up the U.S. health care delivery system.

### The destructive larva syndrome:

Competition turns out to be a variegated cutworm whose destructive larva continues to do its damage long after the plague of moths has flown.

In her report, Rachelle went on to say: "Three pro-competition proposals which have been or will be introduced to Congress during this session were discussed:

1. The Administration's proposal
2. The House of Representatives proposal (H.R. 850)
3. The Senate proposal

**Health and Human Services Secretary Richard Schweiker and Senator H. John Heinz III (R-Pa) discussed the Administration's proposal.** Both noted that the

purpose of competition and the competition legislation being considered was to counteract rising costs. The current outlay of federal dollars is somewhere in the neighborhood of \$200 billion and it is projected that it will be \$438 billion by 1985. Schweiker observed that the incentives in the present health care system are contrary to cost containment efforts:

° the third party payer system

...the "buzzword" - competition - became a "buzzsaw," chopping up the U.S. health care delivery system."

*"...GMENAC predicted there would be a surplus of 69,750 physicians by 1990. We've not been able to nail down this number [+ or -]."*

insulates people from the real costs of health care, consequently, there is no incentive to keep costs low.

- there are no incentives for employers and employees to choose lower priced benefit packages."

We needn't reprint any more of the article, considering that the administration (and whomever else has had a finger in the pie) has driven us to a federal health care expenditure of \$666.2 billion in 1990\* with a projected expenditure of \$1.6 trillion (16.4% of GNP, \$5,712 per capita) in the year 2000.

So, what did pro-competition do for us? Whatever it did and is doing, besides costing us our worldwide model health care delivery system and billions of dollars, it is obviously not the health care reform answer to cost-containment and accessibility.

Two years before Dr. Kaye's report, GMENAC (Graduate Medical Education National Advisory Committee) was believed to have the answer: the United States had too many doctors in some specialties and not enough in others to make competition work effectively; therefore, cap the number of new medical schools, graduates and residencies to control the imbalance. GMENAC may have died for lack of medical or any other care. But from that committee's report came sustenance for the competition larva.

Dr Kaye's report, noted that **Representative Richard A. Gephardt (D. Mo) spoke to the House proposal (H.R. 850 sponsored by Gephardt and others)**, which would 1) establish actuarial categories based on age, sex, marital status, dependents and disability in order to determine healthcare contributions and premium charges; 2) divide the country into urbanized and non-urbanized healthcare areas; 3) entitle all U.S. residents to a healthcare contribution which can take several forms; 4) place a cap on the employer's contribution to employees' purchase of health care plans that may be excluded from the employee's gross income; 5) require the Secretary of Health and Human Services to certify health plans as qualified. Gephardt added that competition in healthcare is already growing, despite political inaction, as a result of the growing physician surplus, too many beds and cost concerns. (GMENAC predicted there would be a surplus of 69,750 physicians by 1990. We've not been able to nail down this number [+ or -] because the parameters of health care keep changing, principally due to changes in Medicare and Medicaid programs. Medicare has moved from 15% of the yearly expenditure in 1980 to 19% in 1990; Medicaid jumped from 10% in 1980 to 11% in 1990, and is expected to increase to 16% by 2000.)

Gephardt wound up his comments, saying that "competition does

\* Source: Health Care Financing Administration



not necessarily contain costs and therefore competition needs to be structured legislatively so that it will." I believe that Gephardt's views have come to fruition, and now he can see what legislatively structured competition has done for the system (the destructive larva syndrome).

**The third major health care initiative** before Congress in 1982 was the Senate plan, which would: 1) amend the Internal Revenue Code to provide that any employer contributions to an employee's health or dental benefit plan which exceeds the limitations established by the legislation would be included in the employee's gross income; 2) require that any employer having more than 100 employees covered under a health benefit plan must provide at least three options, each covered by a separate carrier, that meet requirements pertaining to continuity of coverage, coverage for employees' family, minimum benefits and catastrophic expense protection; 3) provide that the amount of the employer's contribution could not depend on which option an employee chooses; 4) provide that in order for an employer's contribution to be qualified, the contribution must be to a plan or plan option that

- a. provides continuity of coverage in case of death, separation from employment, or divorce
- b. covers an employee's spouse and qualified children
- c. at least provides coverage for the same types of services covered by Medicare
- d. provides for payment of 100% of the cost of minimum benefits provided to a covered individual

during a catastrophic benefit period.

**To cap the whole proceeding,** Minnesota's Republican Senator David Durenberger represented the Senate proposal and he talked, not about the specific legislative proposals, but about government's relationship with health care in general. As an alternative to the proposals and other forms of "controls," Durenberger suggested a new framework for thinking about the way in which government attempts to meet the needs of people. This framework can be expressed in eight guiding principles:

1. *Choices are good; monopolies should be avoided.*

2. *Government is a better purchaser of services than a provider of them.* Government does not allocate resources as well as the private sector does. Consequently, government should get away from directly providing services, including peer review services, and should contract for them.

3. *Consumer choice is enhanced as information increases.* Comparative information should be available to consumers for physicians, hospitals and health care plans based upon which consumer choice can then be made.

4. *The price of a good or service should be a true measure of its cost.* Government should not facilitate hidden costs or cross subsidization.

5. *Government should guarantee access to necessary care; however, standards of access cannot be open ended.*

6. *A responsive market will have*

*"Government is a better purchaser of services than a provider of them."*

*"...the role of the national government in meeting the needs of the people needs to be changed..."*

*fluctuations in capacity.* There will be temporary shifts and increases in capacity as the market adjusts. Government should not be tempted to interfere with it. For example, Certificate of Need, which is an attempt on the part of government to interfere with capacity, should be eliminated.

*7. Government should establish guidelines for quality but recognize that quality will ultimately be judged by the individual.*

*8. The government's role in stimulating competition should be to insure fair market conditions, not to install its own brand of competition.* This can be accomplished by cost sharing of utilized services and/or cost sharing of premiums.

Senator Durenberger concluded by expressing his conviction that the role of the national government in meeting the needs of the people needs to be changed and this cannot be accomplished by simply changing the way in which money is spent. Decisions have to be made about income security and health policy must be given a positive direction.

**Did we learn anything** from all this talk and legislative posturing? Yes, I think we did. Victor Hugo said "No army can withstand the strength of an idea whose time has come." We might add a footnote that some ideas come and go, but in their wake leave untouched the real kernel of motivation: survival. That kernel is, I believe, about to be popped, and when it does give way to the heat the kernel will reveal the fact that mankind (the U.S. variety) is about to consume itself. Maybe this is the

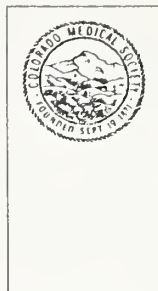
idea whose time has come.

**The gallows theory:** With each passing day, public hue and cry, political and editorial opinion, all become more strident for health care reform. When someone challenges you, the professional care-giver, to describe health care reform or what health care should be, draw your lines carefully, be pragmatic but protracted in your opinions. Look back and see what has gone before. Seek counsel with your fellow practitioner and speak from consensus. Measure your steps carefully and think before you speak. The physician's path of (inner) good intentions, if improperly or incorrectly expressed, might well lead professional fee-for-service practice directly to the gallows. Health care reform advocates are out to hang **somebody!**

As another noted person (source protected) once said, "Nothing better gathers a man's thoughts than the realization that he's about to be hanged."



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## CLASSIFIED ADVERTISING

### ◆ SITUATIONS WANTED

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Susan Anderson, MD, Pioneer Physician

Photo courtesy of the Colorado Historical Society

## September is Women in Medicine Month



Maura J. Lofaro, MSIV

### is Issue:

September: Honoring Women in Medicine .....by Gil Maestas, II, *Colorado Medicine* Staff Writer  
Physicians Must Take Risks, rather than Blame! .....Harrison G. Butler, III, MD, President, CMS  
1992 Leadership Conference—Hope for the Future.....by Leigh Truitt, MD, President-Elect, CMS  
Americans with Disabilities Act—Even More Information.....by Joel M. Karlin, MD with help from CMS legal counsel



# Goals Vs. Performance



## **1981 Goal:**

**Work Toward Eventual Resolution of the Major  
Professional Liability Problems in Colorado**

## **1992 Assessment:**

Goal not yet reached, but we're well on the way. Item:

- As a result of being the first malpractice carrier in Colorado - - if not the nation - - to institute meaningful risk management programs, claims in most specialties are leveling off. The trend is most pronounced in anesthesia, pregnancy and delivery, and most surgical specialties.



## **The bottom line for Copic:**

provide Colorado physicians and, indirectly, the people  
of the state with professional liability insurance which  
is affordable, equitable and fair.





# COLORADO MEDICINE

September, 1992

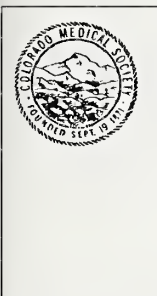
Volume 89, Number 9



## Cover Story

From the days when Susan Anderson, MD brought much needed medical help to the Colorado Rockies, women physicians have helped form the vanguard of medical practice. Today, that tradition continues. See page 304.

## DEPARTMENTS



- 299 President's Letter
- 301 Executive Director's Update
- 308 The Lobby
- 322 Health Department
- 325 New Members
- 328 Medical News
- 330 Classified Advertising

## In This Issue...

- 299 **A Look Back:** The Changing State of Medicine over the Past Nine Years  
*Harrison G. Butler, III, MD*  
*President, Colorado Medical Society*
- 302 **Leadership Conference:** The Physician in the Year 2000  
*Leigh Truitt, MD*  
*President-Elect, Colorado Medical Society*
- 304 **September—Women in Medicine**  
*Gil Maestas, II*  
*Staff Writer, Colorado Medicine*
- 310 **Participation '92—Time to Get Involved!**  
*Ben Galloway, MD*  
*Patti Brown*  
*Co-Chairmen*
- 317 **IRS Loosens Up—Profit Sharing & Retirement**
- 318 **Six Honest Servingmen**  
*Myron Treber, Human Resources Specialist*
- 320 **Americans with Disabilities Act—How to Comply**  
*Joel M. Karlin, MD*  
*AMA Alternate Delegate*



# COLORADO MEDICAL SOCIETY

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor



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*Harrison G. Butler, III, MD  
President, 1991-1992*

**A**s I come to the end of this year as president of the Colorado Medical Society, I have time to reflect on my nine consecutive years of participation in the leadership of CMS.

**S**ix years as a director, one year as a delegate to the House, one year as president-elect and this past year have given me a continuing close-up view of the factors impacting the medical profession.

**I**t's remarkable how the state of medicine has changed over those nine years.

Not only has physician income diminished, even more serious than that is the steady erosion of the authority and reputation of the physician. Though many things have contributed to this decline, I feel that physicians' reluctance to fight for justice for the profession stands out as one of the largest contributors. Admittedly, it's easier to fight amongst ourselves, to criticize, to undermine individuals and groups of physicians. And I have learned that most doctors are disinterested in the political process. We are the **worst** contributors to election campaigns, with all other para-medical professionals out-spending and out-working us for the last several years. Many are disdainful of the medical political action committee, saying they "don't believe in PACs." This is usually a code indicating they don't want to give money to **any** campaign. As a result of this disinterest, physicians have had their political influence steadily eroded. You can plainly see the results. I do not blame the physician for the apathy and malaise, or for becoming a disinterested observer in the process, when I reflect on just how little good our efforts have done during my nine years on the inside. With each accomplishment on our part comes another fusillade from the regulator's side. However, we must not quit trying. It is not too late! It's the very spirit of trying and continuing the struggle most physicians do sustain which gives the profession its standing and its pride as advocates of the patient. The Colorado Medical Society continues to work hard

despite the lack of much-needed support by non-member physicians. The Society is currently fighting several battles that directly affect your business future and your scientific authority. Colorado Medical Society also continues to defend doctors in their struggle against greedy and arrogant insurance companies. A good example of this is our disagreement with automobile insurance companies who have decided, unilaterally, to use the Colorado Workers' Compensation relative value fee as compensation in automobile accident injury cases.

Dr. Jim Crawford of Pueblo recently received a letter which is typical of many letters coming to physicians all over the state. The letter from an employee of ALLSTATE (we'll call her Ms. Smith, though it's probably a computerized pseudonym) accuses Dr. Crawford of "directly affecting insurance premiums" by charging what her company considers "high prices." My reply to Ms. Smith is:

Physicians are not building extravagant skyscrapers and offices that make the Taj Majal look second rate. Physicians do not have CEOs who are paid millions of dollars in compensation. Further, no insurance company has ever treated a sick child or ailing elderly person and, therefore, no insurance company has a clue about what it takes to treat patients. In addition, physicians are subject to the same inflation as everyone else. We have seen our office costs skyrocket over the last five to six years - much of it due to increased cost for insurance of all kinds - life, disability, office overhead, office liability and, yes, health insurance for

---

He's right!

"...physicians must be ready to take some risks!"

our employees. Our premiums on all types of insurance are rapidly escalating, and not because of physicians.

I think we all know that by your company using these reimbursement rates that have been set (artificially low) by the state government, insurance companies are cynically burdening the insured with the unpaid part of the bill, pocketing the difference, then blaming the physician for gouging the patient.

So, Ms. Smith, don't give physicians the self-righteous line that rising costs are all our fault. Shame on you and your greedy employer. The Colorado Medical Society is actively investigating legal and legislative solutions to this kind of behavior and, rest assured, you **will** be hearing from us on this subject.

Roger Shenkle, MD, in Grand Junction stated it eloquently at the CMS Leadership Conference when he said "physicians must be ready to take some risks!" He's right! We can't continue to be expected to underwrite government charity health programs and then be castigated when these underfunded programs run into the red. Leigh Truitt, MD, (CMS president-elect) said it at the July Leadership Conference when he called for physicians to take their rightful role in quality management. Leigh pointed out that he found little opportunity for physicians to be involved in quality management in hospitals, HMOs and outpatient settings. Leigh also remarked at the Leadership Conference that hospitals in Denver are implementing quality management programs without any physician input whatsoever.

My own bias is that each individual physician will have to face the possibility of withholding services in order to be heard. This is

a most onerous step and one that, as a healing professional, is abhorrent. Withholding services, in effect, punishes the wrong person. However, without this step how are physicians going to be heard? How will physician concerns be taken seriously? The other alternative is to continue to be bashed and ridiculed or to quit the practice of medicine. This is not just my own belief, but a belief held by many other physicians. There have been several good friends and excellent physicians who have opted out of medicine recently. This represents a great loss for us all. I have often heard good doctors say they "love to take care of people, but hate the practice of medicine."

This is not a threat, but a simple statement of fact reflecting the frustration and helplessness felt by most physicians in Colorado. Physicians and the practice of medicine are being victimized, and this must be heard. Colorado Medical Society is listening and will continue to strive with all its might to represent the thoughts and concerns of its membership.

At least in the aspect of medical care, we need to be in a management role, directing the course of health care. Are we willing to take that step and assume the mantle of responsibility, or should we lie down and accept the inevitable and the blame?

As I *step down* from office, I fervently hope that Leigh Truitt can *step up* the campaign, with the help of the CMS membership. He will need the support of all Colorado physicians.



# CMS Med Fax<sup>®</sup>

**AT PRESS TIME...**

a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

CMS Med Fax<sup>®</sup>

by **Montgomery Little Young Campbell and McGrew, P.C.**

legal counsel to the Colorado Medical Society

## Free Immunizations

The Children's Hospital and the Colorado Children's Immunization Coalition are sponsoring free childhood immunizations in The Children's Hospital mail lobby October 10 from 10 am to 2 pm.

All childhood immunizations will be available except hepatitis. Other free clinics will be held throughout the area at sites to be announced. For more information, contact Julia Fitzhughes Randolph at 861-8888.

## Are Your Workers Vaccinated?

Beginning in July, the Occupational Safety and Health Administration (OSHA) required employers, including physicians and hospitals, to offer a hepatitis B immunization series to their employees who may come in contact with blood and other infectious materials in the course of their work.

Employers are also required to provide gloves, gowns or face shields for employees to wear when they are at risk for exposure. Inspectors are authorized to visit a work place without advance notice. The AMA informs us that they have been told OSHA will only investigate violations in response to employee complaints.

## Mile High Transplant Bank Breaks Ground for New Facility

The non-profit, community-based, Mile High Transplant Bank broke ground this summer for its new \$2.5 million headquarters building in unincorporated Arapahoe County. Construction of the 16,500 sq. ft. building at 8175 E Harvard Ave is scheduled to be completed by late 1992.

The Mile High Transplant Bank, established in 1981, when bone and tissue banking was in its infancy, recovers, stores and distributes bone and soft tissue for transplantation. The new facility will double the laboratory capacity for handling human tissue.

Jeffrey A. Sandler, Executive Director, said, "We will not only expand our technical capabilities, but we will be able to provide a higher level of quality and service."

More than 300,000 people nationwide received transplants last year, several thousand of them getting bone, saphenous veins, heart valves, cartilage or soft tissue through the Transplant Bank. Ross M. Wilkins, MD, Medical Director, says, "The gift of donation makes death a little easier for family members. Through our ongoing research and the new facility's increased capacity for handling tissue for transplantation, we hope to substantially increase the number of people who are able to receive this gift of life."

## PaperChase Now On Line

CMS members can sign up for the PaperChase medical information access through the Denver Medical Library. PaperChase gives access to Medline, the world's largest biomedical database. Organizer says this is a very user friendly system, designed to keep physicians up to date with the latest medical literature. Unlimited searching is available for \$150 per year. Call 839-6670 for more details.

## Rainer Honored at Alma Mater

W. Gerald Rainer, MD, Past President of the Colorado Medical Society, was honored with the 1992 Distinguished Alumnus Award by the University of Tennessee Medicine Alumni Association recently. The Association said Dr. Rainer had "achieved distinction in active medical practice." Look for more information in *Colorado Medicine* for October, 1992.

**MONTGOMERY  
LITTLE  
YOUNG  
CAMPBELL  
& MCGREW  
ATTORNEYS AT LAW**

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

#### **Medical Education Resources**

**Arrhythmias: Interpretation, Diagnosis and Management**

Las Vegas NV

September 25,26, 1992

(303) 798-9682 or 1-800-421-3756

#### **Medical Education Resources**

**Advances in Vascular Diseases**

Atlantic City NJ

September 25,26, 1992

(303) 798-9682 or 1-800-421-3756

#### **Rocky Mtn College Health Association**

**Annual Fall Meeting**

University of Wyoming, Laramie, WY

September 25-26, 1992

1-800-448-7801 or (307) 766-2124

#### **Colorado Fetal Alcohol & Substance Abuse Coalition**

**Prenatal Exposure to Alcohol & Drugs**

Colorado Convention Center, Denver, CO

October 2,3, 1992

Heather Jones (303) 861-6838

#### **Medical Education Resources**

**Advances in Vascular Diseases**

Orlando FL

October 9-10, 1992

(303) 798-9682 or 1-800-421-3756

#### **Univ. of Calif. Med School Dept. of Radiology**

**Radiology in Africa**

Nairobi, Samburu, Kenya, Masai Mara

October 10-24, 1992

Dawne Ryals (404) 641-9773

#### **Lactation Program—Presbyterian/St. Luke's**

**Contemporary Issues in Breast Feeding**

October 16, 17, 1992

Radisson Hotel, Denver

Elaine (800) 633-6824

#### **Colorado Rural Health Resource Center & Consortium**

**Colorado Rural Health: Creating Our Future**

October 16-18, 1992

Glenwood Springs, CO

(303) 331-8794

#### **Rush-Presbyterian-St. Luke's Medical Center**

**Rush Symposium on Hepatic & Biliary Disease**

Chicago, IL

October 30, 1992

Suzanne Buss, (312) 942-6242

#### **Medical Education Resources**

**Asthma and Allergy in the 1990s**

Las Vegas NV

October 30-31, 1992

(303) 798-9682 or 1-800-421-3756

#### **Medical Education Resources**

**Advances in Vascular Diseases**

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

#### **Medical Education Resources**

**Asthma and Allergy in the 1990s**

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

#### **Radiological Society of North America**

**78th Scientific Assembly & Annual Meeting**

Chicago, IL

November 27 - December 4, 1992

(708) 571-2670

#### **Prosper Meniere Society**

**Diagnostic & Rehabilitative Aspects of Balance & Movement Disorders**

December 2-6, 1992

Denver, CO

Jane Wells (303) 788-4230

#### **Medical Education Resources**

**Coronary Heart Disease Update**

Las Vegas NV

December 4-5, 1992

(303) 798-9682 or 1-800-421-3756

#### **Medical Education Resources**

**Asthma and Allergy in the 1990s**

Key West FL

December 4-5, 1992

(303) 798-9682 or 1-800-421-3756

#### **Medical Education Resources**

**Asthma and Allergy in the 1990s**

New York NY

December 11-12, 1992

(303) 798-9682 or 1-800-421-3756

#### **Stanford University Medical Center**

**Holiday Imaging Update**

Aspen, CO

December 28, 1992 — January 1, 1993

Dawne Ryals, (404) 641-9773

#### **American College of Cardiology**

**24th Annual Cardiovascular Conference**

Snowmass, CO

January 11-15, 1992

1-800-257-4739

#### **Prosper Meniere Society**

**Symposium & Workshops on Surgery of the Inner Ear**

July 20-25, 1994

Snowmass, CO

Jane Wells (303) 788-4230







Sandra L. Maloney  
Executive Director

Thankfully, this is not my "swan song," but I do have to sing... sing the praises of our leadership and the members for their participation during CMS's 1991-92 year.

For starters, let me remind you of a couple of highlights which Colorado physicians can be proud and motivated to do more in '92-93.

Colorado Medical Society was more vocal during this past year than I can remember any years past (without going to court, that is). And the results have been positive. As some of the long-term people around here indicate, it's the first time in 20 or 30 years that the Governor of Colorado has publicly asked Colorado Medical Society to be a part of state planning. Why, you ask?

- **Because** the Governor's office was aware that CMS was a resource not to be forgotten when the new President commenced his term by speaking out and making Coloradans aware that CMS was a body of professionals with divergent opinions and not afraid to express them.
- **Because** CMS had a President who followed through with his agenda and found consensus on some pretty darned hot topics, despite the fact that his own professional views did not agree with others. Yes, he was able to take his lumps and come back swinging, but he got the wheels turning among the members.
- **Because** that same President set the stage for this political year and wasn't afraid to use his best judgment (right or wrong by member standards) on a number of issues and move the Society off dead center.
- **Because** he was a "learner" and continued to bring his opinions forward, no matter that they were voted down or up, and was willing to change his position, attitude or expression (the term "mandatory"

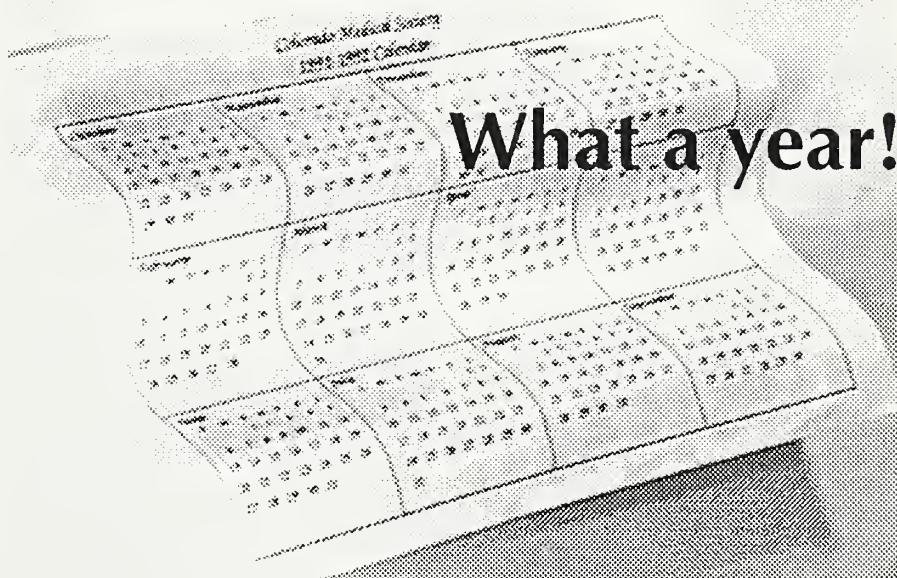
comes to mind).

- **Because** through all the threatening squalls and tumultuous storms he maintained his sense of humor and was continually a delight to work for and with.

Membership voices were heard on many issues, leading to a spirited and healthy exchange of personal and professional views. That's what an association like this needs.

And I genuinely believe that much of this excitement about and in organized medicine is due to Dr. Butler and his spirit and manner of leadership.

Well, what can you say to a guy who came in swinging and is going out swinging. As my spouse said, after asking a friend about getting his wife a gift: In his words, "what can you get a woman who has everything?" His friend replied "A divorce!"



This is not a divorce between "Corky" Butler and CMS, just because he relinquishes the gavel to Leigh Truitt; it is sort of like "separate vacations." And I insist he doesn't stop swinging, because I can look back and can say, with confidence, that this has been one of the healthiest years CMS has had on a lot of fronts. If nothing else, this is one president who knew how to get the blood circulation up; there was no hardening of CMS arteries in its one-hundred, twenty-first year. CMS got an infusion of excitement and "doing things" that is always needed. Corky Butler picked up the tools and positions he had inherited from the John Sbarbaro administration and set out running. Leigh Truitt is already busy reviewing the past and looking to the future (see his summary of the Leadership Conference in this issue) and will continue the good health, high profile society positions.

# 1992 Colorado Medical Society Leadership Conference

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*The physician in the year 2000 is more likely to be younger, female, employed in a group practice, and reimbursed by a pre-paid, capitated plan.*

The focus of the 1992 Leadership Conference was **The Physician in the Year 2000**. That physician is more likely to be younger, female, employed in a group practice, and reimbursed by a pre-paid, capitated plan. Unfortunately, minority representation will probably not increase by much. All of these constituencies are less likely to join the Colorado Medical Society.

We went to Grand Junction to listen. To hear the special concerns of those under-represented in our membership. To learn how we can become more meaningful in their professional lives. To understand how our organizations — component, state and national — can provide benefits to all physicians, not just the "old boys club."

And did we hear! Some of the participants felt obliged to apologize for telling us how the Colorado Medical Society was not meeting their needs. But that was what we came for and I think we will be better for this exercise.

Our keynote speaker was **Richard Lamm**, former Governor of Colorado, who summarized demographic trends as they affect health care. He was eloquent on the problems. His solutions were correct, but not sufficient, in my opinion.

From the Women in Medicine Section, **Louise McDonald**, MD challenged us to develop new and creative policies on parental leave and job sharing. I believe that most of us, both men and women, work too many hours. This trend is

accelerating with changes in the economics of medical practice and other professions. Juliet B. Schor, in *The Overworked American*, has documented that we are working longer and spending less time in leisure activities. Women still bear the major burden of house work and child care. We need realistic model parental leave and job share policies to accommodate all physicians.

**Steve Batuello**, MD, from the Resident Physicians Section, told us that his colleagues feared not only the loss of economic potential in their profession but also declining professional status. I personally believe that the solution to this problem is to encourage physician involvement at all levels of management of health care systems. If we negatively react to change and refuse to participate, we will be ignored. By joining the discussions with enthusiasm and creativity, we can maintain leadership in health care. From that, professional status will flow.

**Jim Regan**, MD, of the Young Physicians Section, spoke of unfulfilled economic expectations of physicians. All of those in primary share his disappointment at the outcome of RBRVS. However, we have not seen the final results. Organized medicine has made a strong and continuing stand in support of primary care.

**Gilbert Maestas**, MD made a moving plea to mainstream so-called minority physicians. I believe that we are doing this successfully. Our failure is in recruitment to both the





Photo: Rocky Mountain News

Leigh Truitt, MD  
President-Elect, Colorado Medical Society

medical schools and the allied health professions that are often a preliminary step to advanced degrees. We intend to work with the University of Colorado to address this problem. Our next topic was practice settings — where and how we actually set up shop. **Jack Berry, MD** gave us the recipe for a successful rural practice. **Roger Shenkle, MD** manages a primary care group practice. In addition, he described Rocky Mountain HMO, a managed care organization with strong physician input that has incorporated both Medicare and Medicaid patients. **Don Parsons, MD** of the Colorado Permanente Medical Group, told us of physician satisfaction in a pre-paid health care plan. We will look more like Kaiser in the future than they will look like us.

**Terry Sullivan, MD**, of Blue Cross/Blue Shield, made some suggestions for health care reform from the viewpoint of a major insurer. As he talked, I could not help but think of the Blues as an opportunity lost. Perhaps they never were the “doctors’ plan.” Certainly, physicians don’t have a good record as the sponsor of IPA’s, PPO’s, or HMO’s. I do see a future in which we might want to achieve more control over our own destiny by establishing our own managed care plan.

The last day was devoted to representatives from organized medicine: **Carol Walker**, from the El Paso County Medical Society; **John O. Cletcher, MD**, representing the

American Academy of Orthopaedic Surgeons; **Sandi Maloney** from the Colorado Medical Society; and **Daniel Johnson, MD**, Speaker of the House of the American Medical Association. They each told us what they offered to their membership in the way of assistance and opportunity. I believe organizations at each level make a unique contribution to our profession.

The weekend was a success. We learned a lot and will put this knowledge to use during the coming year. I am determined that the Colorado Medical Society will justify its claim to speak for all physicians by providing meaningful services and representation to all physicians, not just its members.

Our last lesson was that there is a lot going on outside Denver. The Mesa County Medical Society showed us outstanding hospitality. There is also a level of medical organization and sophistication in certain areas, such as managed care and continuous quality improvement, that surpasses the metropolitan region. Our plan is to bring that expertise to Denver, as well as hold more of our conferences and meetings away from the Front Range.

I would like to thank all of the speakers and other participants. This was a learning experience for the leadership and staff of the CMS. We appreciate the sharing of your concerns and ideas.

*“I am determined that the Colorado Medical Society will justify its claim to speak for all physicians.”*



Photo courtesy of the Colorado Historical Society

# September: "Women In Medicine"

## Issues Often Identified by Women Physicians as Important

- Child care
- Maternity leave
- Balancing family and professional life
- Need for increased representation in organized medicine

*Ed. Note: Information in this article referring to Dr. Susan Anderson comes from the book, "Doc Susie, The true story of a country physician in the Colorado Rockies" (Cornell, V.; Doc Susie, Carpinteria, CA: Manifest Publications).*

*Photo of Dr. Susan Anderson, with this article and on the magazine cover, courtesy of the Colorado Historical Society.*

*Statistical information provided by the American Medical Association*

At the beginning of the Twentieth Century very few women were involved in the practice of medicine. However there were a few brave individuals who chose to fight the system, and rise above the rest in their desire to provide medical care. While researching the history of medical practice in Colorado, I came upon many individuals who have paved the way and proven that barriers of any kind, racial or sexual can be overcome.

**Susan Anderson** was born in Indiana in 1870. During the years of her youth, caring for people came naturally. In 1897 she graduated from the University of Michigan Medical College. That same year she received her Colorado license and began a medical practice in Cripple Creek Colorado during the city's Gold Rush. Ten years later she moved to Fraser, Colorado.\*

For nearly fifty years she was the only licensed physician in the area. She was known as "Doc Susie" and practiced pioneer medicine in a primitive country. Several times she used an old corset for a rib belt and performed surgery in a log cabin<sup>1</sup>. Susan Anderson M.D. was truly a **"Medical pioneer of Colorado."**

The science and practice of medicine has changed drastically since the days of "Doc Susie" and so have the number and specialties of women physicians.

September, 1992, marks the third AMA celebration of women physicians' history and accomplish-

ments. The AMA points up the tremendous progress made by women in medicine.

Currently the position of Surgeon General of the United States is held by Dr. Antonia Novello. The total number of women physicians more than doubled between 1970-1980; by 1990, the number had increased over 300% to approximately 104,000, or 16.9% of all physicians. Future projections presented by the AMA state that by the year 2010, 30% of physicians will be women. Two-thirds of women in residency training are found in five specialties; internal medicine, pediatrics, obstetrics/gynecology, family practice and psychiatry. Efforts should be made to encourage gender diversity in all specialties and to eliminate any specialty selection barriers that may exist.

Women are widely accepted and respected in medicine today. They are represented at all levels of the profession and have assumed top roles in public health, health policy, administration, science, research and academia. Nevertheless, women continue to report instances of sexual discrimination/ harassment and gender-based stereotyping particularly in medical school and residency training. Eighty-one percent of females responding to a 1988 AMA survey of a third-year medical school class reported that they had been subjected to sexist slurs. Other respondents reported sexual advances, denied opportunities, and



other forms of sexual discrimination.

During an interview, **Maura Lofaro**, Medical School Component Delegate to the CMS Board of Directors, shared her feelings and experiences on becoming a physician in the '90s. Becoming a physician is hard work. Being a woman physician may present situations that male counterparts might not experience. While undergoing the process of interviewing for medical school, Maura recalls a male professor who was really not interested in her background and experience. She felt that she was being looked at as a woman, and not as an individual with a strong desire to practice medicine.

She was also interviewed by a female professor at the same institution. The feeling was different, and attention was given to the specifics of her education. Maura also stated that she feels attitudes will change as time passes. Many of the older male physicians were raised in a time when sexist attitudes were not only accepted but encouraged. As far as experiences with fellow students and mentors, all have been positive. Maura plans to receive her license to practice medicine within the next two years. She will specialize as an Obstetrician/Gynecologist.

As stated previously, By the year 2010, 30% of physicians will be women. There are many issues that must be dealt with. It is important to regard women as physicians first—concerned about the same profes-

sional and health care issues as are their male colleagues—but at the same time, recognize that there are some key issues primarily of concern to women physicians.

## Issues Often Identified by Women Physicians as Important

- Child care
- Maternity leave
- Balancing family and professional life
- Need for increased representation in organized medicine

**Deborah Bublitz** M.D., Pediatrician and CMS member, offered a look into her personal experiences while studying medicine in the 50's at John Hopkins University. Dr. Bublitz explains that while most of her friends were getting married and starting families, she was entering medical school. Her family always provided full support and encouragement. Society did not. At that particular point in time, the medical school had a quota for female applicants that had to be filled. Women were expected to stay within boundaries and not show emotions. As Dr. Bublitz expressed, "These attitudes never upset me. I was where I wanted to be, studying medicine. It helps to have a sense of humor and make the best of any situation."

During the 70's Dr. Bublitz started a family. She took approximately six years away from a full-time practice. This period proved to be a learning experience that has



*Maura J. Lofaro, MSIV*



*Deborah K. Bublitz, MD*

*References*  
*'Rocky Mountain News, Denver, Colorado,*  
*April 21, 1960.*

# Women in Medicine

*continued...*



*Louise L. McDonald, MD*

enriched her practice of Pediatrics. "Having children of my own gave me a new perspective. All previous theories went out the window. Now I feel what a parent is going through with their children and it enables me to offer practical as well as scientific solutions. Motherhood was a humbling experience." She went on to say "All individuals are unique. Regardless of gender everyone has something to offer. Women in medicine offer different perspectives, and bring a needed change. Medicine loses when women are not respected".

A recent interview with **Louise L. McDonald, M.D.**, Medical Director of Student Health Services for the University of Denver, and CMS Board of Directors representative from the Women in Medicine section, offered some valuable insight. Dr. McDonald has practiced medicine for over thirty years. She says that not becoming involved in organized medicine alienates the physician from the main stream. "When you wait until your children are grown up before you get involved, the whole setting becomes more intimidating," she explains, "It is still ingrained in women that it's still the man's job to lead. This is

simply not the case." Dr. McDonald feels that increased visibility through high leadership positions, management training, and programs that utilize affirmative action will increase the number and leadership power of women in medicine. "The day will come," she says, "when female physicians will be judged solely on the manner in which they care for patients. But before it does, there's still a lot of work to do to overcome sexist attitudes. We female physicians have to participate on our medical staffs, get involved in organized medicine, get active in our communities. We cannot 'leave it up to the men.' Indeed, we should spend quality time at home, but we should make appropriate arrangements for our children and then stop feeling guilty about our time away from them. That's hard, and it may always be harder for women in medicine than for men because we may always be ultimately responsible for child care and home care. But if we don't make our voices heard, we'll be ignored. Few female wimps go into medicine—we're up to the challenge!"





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## THE LOBBY

Alan D. Rapp, MD, Chairman  
Council on Legislation  
with  
Sue Ellen Quam, Lobbyist/Director  
CMS Government Relations  
and  
Lorraine Koehn  
Program Manager/Lobbyist

The Colorado Medical Society actively supported the amended SB92-3 - **Concerning Patient Autonomy In Regard To The Making Of Medical Treatment Decisions** and spent the majority of the session advocating its passage.

Colorado Medical Society also hosted a "Thank You, Legislature" party at the University Club, just to say thanks for a job well done in this session.

On hand were members of the CMS Council on Legislation, Alan Rapp, MD, Chairman, and CMS staff members of the Director's Office and Government Affairs Department.



Louise D. C. Walker, MD, (right) member of the CMS Legislative Council.



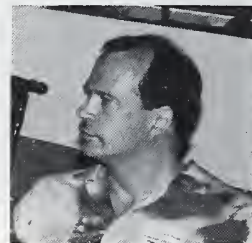
Pictured above is the group principally responsible for working SB92-3 through the legislature and its signing into law. They are (l to r) Lorraine Koehn, Gary Davis, Sue Ellen Quam, Fredrick Abrams, MD, Judge Field Benton, Dorothy Hillbrand, Garth Grissom, Sen. Dottie Wham, David Murphy, MD, unidentified, Stewart Griesman, MD, Peter Pons, MD, and Nell Tramp of AARP. Seated in wheelchair is Mildred Stanley, eloquent spokesperson for SB92-3.



Governor Romer prepares to sign SB92-3, the "Death with Dignity" bill, as Mildred Stanley (l-seated) looks on. Also pictured were key players in the bill's passage, (l to r) Rep. Bonnie Allison, Sen. Dottie Wham, Robert Steenrod, Stewart Griesman, MD, Peter Pons, MD, Fredrick Abrams, MD, Judge Field Benton, Rep. Marlene Fish (behind Rep. Fish, Donald Murphy, MD, Sue Ellen Quam,) Nell Tramp, AARP, David Murphy, MD, and Dorothy Hillbrand. Not in the picture but an important player on hand was Edith Sherman, MD.



Alan Rapp, MD, talks with Representative Donald Mares



Legislative Council member Richard O. Hammond, MD, of Larimer County.





W. Ben Galloway, MD, "Participation '92 co-chairman, talking with Rep. Charles Henning and Sen. Paul Schauer



Representative Betty Neale can smile, now that the session is sine die



Judge Field Benton enjoys a chuckle with one of the reception guests



Representatives Bonnie Allison (l) and Marlene Fish talking with Colorado MGMA Government Affairs staff member Frank Dinger.



Rep. Phil Pankey can smile through the harshest of receptions



Rep. Pat Sullivan, MD, is about to (or has just said) something of considerable bearing on this (or the next) session

Approximately 35 legislators attended the CMS Council on Legislation/ Government Affairs "Thank You" party. It was a time to review the session and to speculate on what would be in the making for the coming session. In addition to SB92-3, there were other highlights of the session, including:

**SB92-65 Concerning the reform of methods for providing medical assistance to indigent persons in Colorado.** CMS does endorse the concept of studying and revising the current Medicaid program and would like to be an integral player in this process.

**HB92-1340 Access to Workers' Compensation files.** CMS believed that this bill will prove to be detrimental to injured workers because it negated the protection provided in the limited waiver of doctor-patient confidentiality

**HB92-1306 Concerning the delivery of services pursuant to the "Colorado Medical Assistance Act through managed care."** CMS voiced its *strong opposition* to Section 26-404(b) (1) of the bill which mandated that the Department of Social Services pay the lower of Medicare/Medicaid reimbursement when individuals have dual eligibility.

In 1992, CMS followed 49 state legislative proposals. This year CMS supported 16 bills - 11 passed; 5 were killed. CMS opposed 5 bills - all 5 were killed. CMS monitored 26 bills but many of the bills which were monitored were amended by CMS lobbyists and physicians. This allowed CMS to change its original position of "oppose" to a "monitor" stance. CMS also had to say goodbye to three good friends in the legislature: Representatives Betty Neale (not running for re-election), Marlene Fish and Bonnie Allison. (both defeated in the primary).



State Representative Bill Martin and Senator Dottie Wham enjoying a few reflections on the session with Dr. Alan Rapp, Legislative Council Chairman



# Physician Participation is Critical

## Time to Get Involved!

*Call your County Clerk's Office or County Elections Commission to find out what district you are in.*

Actually, it has been time to get involved for several months. However, the time has come for a more direct role in political activities. The primaries are over, the candidates have been chosen. The "real" campaigns are now underway.

In many races, there are now two candidates, one Democrat, one Republican (After August 24, the Secretary of State's office will have certified some Independent candidates as well). Some are incumbents, many are not. The redrawing of district boundaries earlier this spring has made many cases of "a whole new ball game." Ignore your old district number and call your County Clerk or Elections Commission to find out your new one.

It is more important than ever that you get involved in the campaign of your chosen candidate(s). First, we trust that you will want to see the candidates elected who already believe as you do about health care. Working in the campaign will help get those sympathetic people elected.

Secondly, your participation in the campaign will give you a receptive ear when issues of importance to the medical community arise. Your legislator will be more likely to respect your opinion since you helped in the election campaign.

Legislative races are largely won on a local level. Here are the names and addresses of the candidates (Note: Several of these races were very close. It is not yet known how any recount may affect the outcome.). Pick out the ones who want to represent your district and get involved in the campaign today. There's no better way to ensure good relations between physicians and legislators.

**US SENATE**  
**Democrat**  
Ben Nighthorse Campbell  
PO Box 480166  
Denver 80248  
(303) 837-0565

**US Congress—1st District**  
**Democrat**  
**Pat Schroeder**  
1600 Emerson  
Denver 80218  
(303) 866-1230

**US Congress—2nd District**  
**Democrat**  
**David Skaggs**  
9109 Harlan Room 130  
Westminster 80030  
(303) 650-7886

**US Congress—3rd District**  
**Democrat**  
Mike Callihan  
PO Box 54  
Gunnison 81230  
(303) 320-3918

**Republican**  
Terry Considine  
2135 S Cherry Ste 310  
Denver 80222  
(303) 757-2567

**Republican**  
Raymond Diaz Aragon  
1177 Race St Apt #1007  
Denver 80206  
(303) 320-6607

**Republican**  
Bryan Day  
9032 W 88th Ave  
Westminster 80005  
(303) 422-8692 F 727-6631

**Republican**  
Scott McInnis  
PO Box 1  
Glenwood Springs 81601  
(303) 832-4900





**Ben Galloway, MD**  
Chairman  
CMS Participation '92

**Patti Brown**  
CMS Auxiliary Legislative Affairs Chairman 1991-1992  
Co-Chairman CMSA Participation '92

**US Congress—4th District**

**Democrat**  
Tom Redder  
PO Box 96216  
Fort Collins 80525  
(303) 224-9767

**Republican**  
**Wayne Allard**  
134 W Harvard  
Fort Collins 80525  
(303) 226-2226

**US Congress—5th District**

**Democrat**  
Charlie Oriez  
7975 S Datura Cir W  
Littleton 80120  
(719) 633-2559 or  
(303) 798-3236

**Republican**  
**Joel Hefley**  
1625 Woodmen Rd  
Colorado Springs 80919  
(719) 520-0055  
or (303) 969-7791

**US Congress—6th District**

**Democrat**  
Tom Kolbe  
3822 E Costilla  
Littleton 80122  
(303) 850-9867

**Republican**  
**Dan Schaefer**  
PO Box 1654  
Englewood 80150  
(303) 989-2100

**COLORADO SENATE DISTRICT 4**

**Democrat**  
Linda Powers  
PO Box 665  
Crested Butte 80124  
(303) 349-5798

**Republican**  
**Harold McCormick**  
927 Greenwood Ave  
Cañon City 81212  
(719) 275-9518

**COLORADO SENATE DISTRICT 8**

**Democrat**  
Eagle Garfield Grand Jackson Moffat Rio Blanco Routt  
**Republican**  
**Dave Wattenberg**  
Drawer 797  
Walden 80480  
(303) 723-4577 or  
723-4326

**COLORADO SENATE DISTRICT 10**

**Democrat**  
El Paso (East and Southeast Colorado Springs)  
**Republican**  
**Ray Powers**  
5 N Marksheffel Rd  
Colorado Springs 80929  
(719) 596-1055

**COLORADO SENATE DISTRICT 12**

**Democrat**  
Southwest El Paso and Teller

**Republican**  
**Mary Anne Tebedo**  
1916 Snyder Ave  
Colorado Springs 80909  
(719) 471-2561

**COLORADO SENATE DISTRICT 14**

**Democrat**  
Larimer (Fort Collins)  
William F Steffes  
PO Box 1153  
Fort Collins 80522

**Republican**  
**Bob Schaffer**  
3723 Gunnison Dr  
Fort Collins 80526  
(303) 223-7805

**COLORADO SENATE DISTRICT 17**

**Democrat**  
Boulder (Longmont Louisville Lafayette Niwot)  
Paul Wiseman  
822 Lafarge Ave  
Louisville 80227  
(303) 673-0191

**Republican**  
**David Leeds**  
PO Box 442  
Louisville 80227  
(303) 673-0282

**COLORADO SENATE DISTRICT 18**

**Democrat**  
Boulder  
**Jana Mendez**  
3015 24th St  
Boulder CO 80304  
(303) 442-7110

**Republican**

**COLORADO SENATE DISTRICT 19**

**Democrat**  
Jefferson  
Evie Hudak  
7649 Harlan Way  
Arvada 80003  
(303) 421-2155

**Republican**  
**Al Meiklejohn**  
7540 Kline Dr  
Arvada 80005  
H (303) 422-2092 B 573-1600

**COLORADO SENATE DISTRICT 21**

**Democrat**  
Jefferson  
Michael F Feeley  
866-G S Reed Ct  
Lakewood 80226  
(303) 936-9680

**Republican**  
Lynn Watwood  
14083 W Alaska Dr  
Lakewood 80228  
(303) 988-0897

**COLORADO SENATE DISTRICT 23**

**Democrat**  
Adams  
Lloyd Casey  
10434 Carmela Ln  
Northglenn 80234  
(303) 452-8515

**Republican**  
Ted Strickland  
9361 Knox Ct  
Westminster 80030  
(303) 426-7676

**COLORADO SENATE DISTRICT 25**

**Democrat**  
Adams  
**Bob Martinez**  
6462 E 63rd Ave  
Commerce City 80022  
(303) 287-8111

**Republican**  
David Mitchell  
6641 E 64th Ave  
Commerce City 80022  
B(303) 287-0300 F 287-0236

**COLORADO SENATE DISTRICT 26**

**Democrat**  
Arapahoe Jefferson  
Lloyd Covens  
PO Box 3362  
Littleton 80161  
(303) 797-9523 797-7201

**Republican**  
**Tom Blickensderfer**  
9 Parkway Dr  
Englewood 80110  
H (303) 758-0146 B 320-6100

**COLORADO SENATE DISTRICT 27**

**Democrat**  
Arapahoe

**Republican**  
**Bill Owens**  
15928 E Mercer Cir  
Aurora 80013  
(303) 693-3092

**COLORADO SENATE DISTRICT 28**

**Democrat**  
Arapahoe (Aurora)  
Belle Miran  
2886 S Wheeling Way  
Aurora 80014  
(303) 752-3975

**Republican**  
Elsie Lacy  
11637 E Mexico Ave  
Aurora 80012  
(303) 750-5943

**COLORADO SENATE DISTRICT 29**  
*Arapahoe (Aurora)*

**Democrat**  
Steve Ruddick  
1031 Sable Blvd  
Aurora 90011  
(303) 360-0715 360-7406

**COLORADO SENATE DISTRICT 31**  
*West Denver*

**Democrat**  
Donald Mares  
2441 Perry St  
H (303) 433-3559 B 433-5037

**COLORADO SENATE DISTRICT 33**  
*Adams Northeast Denver*

**Democrat**  
**Regis Groff**  
2079 albion  
Denver 80207  
H (303) 320-0495 B 764-3578

**COLORADO SENATE DISTRICT 35**  
*Arapahoe Southeast Denver*

**Democrat**  
Mike Johnson  
1581 S Krameria  
Denver 80224  
(303) 758-5735

**COLORADO HOUSE DISTRICT 1**  
*Southwest Denver*

**Democrat**  
Marion Thornton  
1573 S Alcott  
Denver 80219

**COLORADO HOUSE DISTRICT 2**  
*West Denver*

**Democrat**  
**Tony Hernandez**  
1285 S Clay  
Denver 80219  
(303) H 922-4388 B 773-5000

**COLORADO HOUSE DISTRICT 3**  
*South Denver Englewood Sheridan*

**Democrat**  
**Wayne Knox**  
761 S Tejon  
Denver 80223  
(303) 934-8707

**COLORADO HOUSE DISTRICT 4**  
*Northwest Denver*

**Democrat**  
**Rob Hernandez**  
4600 W 36th Ave  
Denver 80212  
(303) 456-1011

**COLORADO HOUSE DISTRICT 5**  
*North Denver*

**Democrat**  
**Celina Benavidez**  
2825 W 34th Ave  
Denver 80211  
(303) 477-2867

**COLORADO HOUSE DISTRICT 6**  
*East Central Denver Glendale*

**Democrat**  
Diana DeGette  
290 Elm St  
Denver 80220  
(303) 388-6399 839-3767

**COLORADO HOUSE DISTRICT 7**  
*Northeast Denver*

**Democrat**  
**Gloria Tanner**  
2150 Monaco Pkwy  
Denver 80207  
(303) 355-7288 388-2260

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David Rowberry  
17842 E Wyoming Pl  
Aurora 80017  
(303) 268-2336 220-7945

**Republican**

**Republican**  
John Dates  
1285 Roslyn St  
Denver 80220  
(303) 377-4911

**Republican**  
**Dottie Wham**  
2790 S High  
Denver 80210  
H (303) 757-0615

**Republican**  
**Jeanne Faatz**  
2903 S Quitman  
Denver 80236  
(303) 935-6915

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Ted Harvey  
1250 Galapago #805  
Denver 80204  
(303) 534-4011

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**Chuck Henning**  
2951 S Franklin  
Englewood 80110  
(303) 781-8754

**Republican**  
Ron Vertees  
2534 W 40th Ave  
Denver 80211  
(303) 477-7528

**Republican**  
Tom Knorr  
950 Pearl St  
Denver 80203  
(303) 830-2109

**Republican**  
Clark Houston  
715 Franklin  
Denver 80218  
(303) 322-8976

**Republican**  
Athena Eisenman  
5180 Deeplaven Ct  
Denver 80239  
(303) 373-1445

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2080 Emerson  
Denver 80203  
(303) 894-0608

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**Democrat**  
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977 S Ogden  
Denver 80209  
(303) 733-1363 759-3000

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**Democrat**  
Doug Friednash  
3371 S Magnolia St  
Denver 80224  
(303) 321-3132 H 832-1900

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**Democrat**  
**Ruth Wright**  
1440 High St  
Boulder 80304  
(303) 443-8607

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37 Princeton Cir  
Longmont 80503  
(303) 772-3890

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6485 Luther Rd  
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Colorado Springs 80903  
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4525 Del Verde Dr  
Colorado Springs 80918  
(719) 598-6020

**Republican**  
Stuart McPhail  
1133 Race St (14N)  
Denver 80206  
(303) 321-2082 839-1738

**Republican**  
Dick Bettinger  
1820 S Columbine  
Denver 80210  
(303) 733-2266

**Republican**  
Kathy Finger  
4035 S Niagara Way  
Denver 80237  
(303) 756-5893

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Bib McDonald  
8187 N 73rd St  
Longmont 80503  
(303) 772-2221

**Republican**  
Bonnie Finley  
50 Cornell Dr  
Longmont 80503  
(303) 772-1243

**Republican**  
Drew Clark  
876 Dearborn  
Boulder 80303  
(303) 494-1251

**Republican**

**Republican**  
Ron May  
730 Citadel Dr E  
Colorado Springs 80909  
(719) 591-8620

**Republican**  
**Bill Martin**  
3110 Lees Ln  
Colorado Springs 80909  
(719) 634-8729

**Republican**  
Victor Mote  
2025 Eddington Way  
Colorado Springs 80916  
(719) 597-2789 B 596-8212

**Republican**  
**Tom Ratteree**  
7312 Bell Dr  
Colorado Springs 80920  
B (719) 528-6457



**COLORADO HOUSE DISTRICT 19***El Paso***Democrat**

Don Davidson  
6725 Sullivan Ave  
Widefield 80911  
(719) 392-4091

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Mike Duncan  
3427 W Kiowa  
Colorado Springs 80904  
(719) 633-9977

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1326 Allison #3  
Lakewood 80215  
(303) 237-7403

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4325 Iris  
Wheat Ridge 80033  
(303) 425-0130

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305 LookoutView Dr.  
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11249 W. Oregon Dr.  
Lakewood 80232

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6833 Welch Ct.  
Arvada 80004  
(303) 431-8459

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9317 Ingalls  
Westminster 80030  
(303) 426-1202

**Republican***Mary Ellen Epps*

217 Dexter St  
Colorado Springs 80911  
(719) 392-3861

**Republican***Charles Duke*

1711 Woodmoor Dr  
Monument 80132  
H (719) 481-9289

**Republican***Chuck Berry*

314 Pine Ave  
Colorado Springs 80906  
(719) 634-6328

**Republican**

Marcy Morrison  
302 Sutherland Pl  
Manitou Springs 80829  
(719) 685-5929

**Republican**

Penn Pfiffner  
38 S Zinnia Way  
Lakewood 80228  
H (303) 988-3717 B 650-9239

**Republican**

Rod Hayes  
3450 Estes St  
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H (303) 231-9981 B 238-0566

**Republican**

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3237 S. Hiwan Dr.  
Evergreen 80439  
(H) (303) 647-7883 B 277-2311

**Republican***Shirleen Tucker*

615 S. Eldridge  
Lakewood 80228  
(303) 988-0118

**Republican***Pat Miller*

7325 Tabor St.  
Arvada 80005  
(303) 421-2261

**Republican***Vicki Agler*

10289 W. Burgundy Ave.  
Littleton 80127  
(303) 937-1987

**Republican***Michelle Lawrence*

6362 Depew  
Arvada 80003  
(303) 420-7654 B 424-6640

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1958 S. Taft St.  
Lakewood 80228  
(303) 969-9241

**COLORADO HOUSE DISTRICT 31***Adams, Boulder, Weld***Democrat**

Robert (Dutch) Shindler  
609 Avante Ct.  
Lafayette 80026

**COLORADO HOUSE DISTRICT 32***Adams***Democrat***Jeannie Reeser*

9883 Pearl St.  
Thornton 80229  
(303) 482-1838

**COLORADO HOUSE DISTRICT 33***Adams***Democrat***Carol Snyder*

11756 Elati Ct.  
Northglenn 80234  
(303) 452-7043 B 592-5900

**COLORADO HOUSE DISTRICT 34***Adams***Democrat**

Alice Nichol  
891 E. 71st  
Denver 80229  
(303) 288-1319

**COLORADO HOUSE DISTRICT 35***Adams***Democrat***Vi June*

7500 Wilson Ct.  
Westminster 80030  
(303) 429-1161

**COLORADO HOUSE DISTRICT 36***Adams***Democrat**

Don Armstrong  
1757 Galena St.  
Aurora 80010  
(303) 366-7074

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Scott Levin  
6312 S. Florence Way  
Englewood 80111  
(303) 740-7232 B 850-7887

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Robert Haines  
7903 South Franklin Ct.  
Littleton 80122  
(303) 798-3902

**COLORADO HOUSE DISTRICT 39***South Arapahoe***Democrat**

Mary Palley Gruber  
7009 S. Valencia  
Englewood 80112  
(303) 220-8122

**COLORADO HOUSE DISTRICT 40***South Aurora***Democrat**

Ron Anderson  
4068 S. Fundy Way  
Aurora 80013  
(303) 680-5620

**Republican***Norma Anderson*

10415 W. Hampden  
Lakewood 80227  
(303) 986-0397

**Republican***Faye Fleming*

12424 N. Ash St.  
Thornton 80241  
(303) 450-2248

**Republican****Republican**

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Northglenn 80234  
(303) 469-6394

**Republican**

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Westminster 80030  
(303) 466-8206

**Republican**

Steve Willner  
5395 Quilman  
Denver 80212  
(303) 458-8873 B 480-1956

**Republican**

Don Hamstra  
556 S. 15th Dr.  
Brighton 80601  
(303) 654-0732 B 659-1531

**Republican**

Martha Kreutz  
6023 S. Bellaire Way  
Littleton 80121  
B 779-1019

**Republican***Phil Pankey*

5763 Shasta Cir.  
Littleton 80123  
(303) 798-5873

**Republican***Paul Schauer*

7255 S. Jackson Ct.  
Littleton 80122  
(303) 770-3872 B 744 5638

**Republican***Mike Coliman*

P.O. Box 440740  
Aurora 80044  
(303) 766-0918 B 671-6402

**COLORADO HOUSE DISTRICT 41***South Aurora***Democrat****Peggy Kerns**

1124 S. Oakland Ct.

Aurora 80012

(303) 696-7178

**Republican****John Fritschler**

2822 S. Oakland Circle East

Aurora 80014

(303) 324-0699

**COLORADO HOUSE DISTRICT 52***Larimer (East Fort Collins)***Democrat****Bernie Strom**

525 Spring Canyon Ct.

Fort Collins 80525

(303) 223-9900 B 225-0055

**Republican****Dan Nygaard**

1609 Shenandoah Cr.

Fort Collins 80525

(303) 226-0773 B 493-4054

**COLORADO HOUSE DISTRICT 42***Aurora***Democrat****Bob Hagedorn**

11633 E. 6th Pl.

Aurora 80010

(303) 343-1758 B 321-4588

**Republican****Eugene Hogan**

1063 Fairplay St.

Aurora 80111-7025

(303) 364-8376 B 340-0060

**COLORADO HOUSE DISTRICT 53***Larimer (West Fort Collins)***Democrat****Peggy Reeves**

1931 Sandalwood Lane

Fort Collins 80526

(303) 482-8952 B 229-9200

**Republican****Dave Goff**

2625 Pampas Dr.

Fort Collins 80526

(303) 493-8662

**COLORADO HOUSE DISTRICT 43***Northeast Aurora***Democrat****Roger Henderson**

715 Mobile St.

Aurora 80011

(303) 364-0964

**Republican****Debbie Allen**

923 S. Ouray St.

Aurora 80017

(303) 695-4920 B 695-0588

**COLORADO HOUSE DISTRICT 54***Delta, Mesa***Democrat****Bill Baird**

929 E. Laura

Fruita 81521

(303) 858-3989

**Republican****Tim Foster**

593 Village Way

Grand Junction 81503

(303) 245-8440 B 245-8021

**COLORADO HOUSE DISTRICT 44***Custer, Fremont, Pueblo, Teller***Democrat****Bob Shoemaker**

6484 County Rd. 9

Canon City 81212

(719) 275-6232

**Republican****Larry Schwartz**

686 Custer County Road 297

Wetmore 81253

(719) 784-3315 B 372-6390

**COLORADO HOUSE DISTRICT 55***Mesa***Democrat****Dan Prinster**

P.O. Box 3884

Grand Junction 81501

(303) 241-5015

**Republican****COLORADO HOUSE DISTRICT 45***Pueblo***Democrat****Bill Thiebaut**

P.O. Box 262

Pueblo 81002

(719) 544-3822

**Republican****Mike Occhiato**

11 Harrogate Terrace

Pueblo 81001

**COLORADO HOUSE DISTRICT 56***Eagle, Garfield, Grand, Jackson, Routt***Democrat****Jamison Smith**

P.O. Box 3126

Vail 81658

(303) 827-4274 B 476-5631

**Republican****Jack Taylor**

Box 5656

Steamboat Springs 80477

(303) 879-3600

**COLORADO HOUSE DISTRICT 46***Pueblo***Democrat****Gil Romero**

1128 Catalpa St

Pueblo 81001

(719) 544-2420 B (719) 543-9591

**Republican****COLORADO HOUSE DISTRICT 47***Baca, Bent, Crowley, Las Animas, Otero, Pueblo***Democrat****John Singletary**

58332 Elderberry Rd.

Boone 81025

(719) 846-2523

**Republican****Mike Salaz**

124 East 2nd

Trinidad 81082

(719) 846-9527

**COLORADO HOUSE DISTRICT 58***Delta, Dolores, Montezuma, Montrose, Ouray, San Miguel***Democrat****Dave Williams**

P.O. Box 585

Norwood 81423

**Republican****Steve Acquifresca**

2290 Road S

Cedaredge 81413

(303) 856-6358

**COLORADO HOUSE DISTRICT 48***Weld***Democrat****Mel Foxhaven**

2100 26th Ave.

Greeley 80631

(303) 330-5292

**Republican****Dave Owen**

2722 Buena Vista Dr.

Greeley 80631

B (303) 330-9600

**COLORADO HOUSE DISTRICT 59***Archuleta, La Plata, Montezuma, San Juan***Democrat****Jim Dyer**

Box 5225

Durango, 81302

(303) 259-1942 B. 247-1777

**Republican****COLORADO HOUSE DISTRICT 49***Weld, Larimer (rural)***Democrat****David Morgan**

409 Bothun Rd.

Berthoud 80513

(303) 523-3249

**Republican****Bill Jerke**

23003 WCR 39

La Salle 80645

(303) 284-6061

**COLORADO HOUSE DISTRICT 60***Alamos, Conejos, Costilla, Huerfano, Las Animas, Mineral, Rio**Grande, Saguache***Democrat****Lew Entz**

Silver Jaramillo

P.O. Box 333

Ft. Garland 81133

(719) 379-3677

**Republican****Lew Entz**

1016 North 11 Lane

Hopper 81136

(719) 754-3750

**COLORADO HOUSE DISTRICT 50***Weld,***Democrat****Sue Schulze**

1814 Reservoir

Greeley 80631

**Republican****Pat Sullivan**

2411 19th Ave.

Greeley 80631

(303) 352-5066

**COLORADO HOUSE DISTRICT 61***Chaffee, Gunnison, Hinsdale, Lake, Park, Pitkin, Teller***Democrat****Republican****Ken Chlouber**

220 W. 8th

Leadville 80461

(719) 486-0008

**COLORADO HOUSE DISTRICT 51***Larimer (Loveland)***Democrat****Republican****John Irwin**

3334 Bent Dr.

Loveland 80538

(303) 669-0317



**COLORADO HOUSE DISTRICT 62**  
 Clear Creek, Gilpin, Jefferson, Summit  
**Democrat**  
**Sam Williams**  
 Box 2159  
 982 High Point Dr.  
 reckenridge 80424  
 (303) 453-1586 B 453-2863

**Republican**  
**Leona Hemmerich**  
 6757 Highway  
 Idaho Springs 80452  
 (303) 567-4800

**COLORADO HOUSE DISTRICT 64**  
 Douglas  
**Democrat**

**Republican**  
**Jeanne Atkins**  
 6517 N. Pinewood Dr.  
 Parker 80134  
 (303) 841-8829

**COLORADO HOUSE DISTRICT 63**  
 Arapahoe, Cheyenne, Elbert, Kiowa, Kit Carson, Lincoln, Prowers,  
 Yuma  
**Democrat**  
**B. Smith**  
 P.O. Box 1117  
 12 S. Banner  
 Elizabeth 80107  
 (303) 646-3209

**Republican**  
**Bud Moellenberg**  
 6946 County Road R  
 Kirk 80824  
 (303) 362-4391

**COLORADO HOUSE DISTRICT 65**  
 Logan, Morgan, Phillips, Sedgwick, Washington  
**Democrat**  
**Bob Eisenach**  
 14750 Road 16  
 Fort Morgan 80701  
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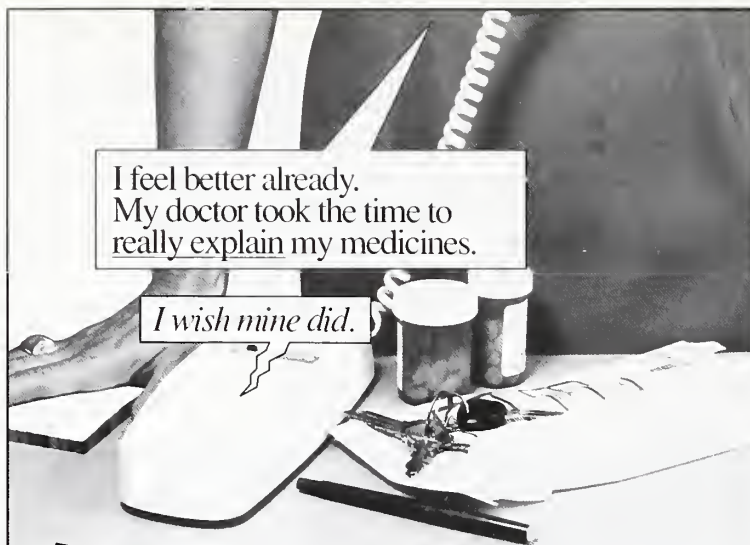
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## Smoke Free Dining Guide

The Group to Alleviate Smoking Pollution (GASP) of Colorado has released its updated *Guide to Smoke-Free Dining in Colorado*, one of the most comprehensive directories of its kind in the country. The guide, free to the public, lists more than 300 restaurants in the state which are 100% smoke free.

Peter Bialick, president and founder of the Colorado chapter of GASP, said, "The number of smoke free restaurants in Colorado has tripled since our last guide was published in 1989. We see the trend toward more smoke free restaurants as a positive step toward the day when all restaurants are smoke free."

Since the EPA has classified environmental (second-hand) tobacco smoke (ETS) as a Class A carcinogen, this is a significant health problem. Class A substances are proven to cause cancer in humans. Exposure to ETS causes lung cancer, and heart disease, and is especially dangerous to children.

Mr. Bialick says, "Separate smoking areas in restaurants do not provide adequate protections for the public. A nonsmoking area can only be smoke free if it is completely enclosed and is independently ventilated."

For a copy of the guide, which covers five geographic regions in Colorado, call (303) 444-9799.

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# IRS Becomes More Liberal for Profit-Sharing Retirement Programs

In 1991, the Internal Revenue Service (IRS) authorized the approval of a new formula for profit-sharing programs. Previously, profit-sharing programs required a uniform percentage of the participants' annual earnings as a contribution to the program. The Service now takes into account older owners/employees have fewer years to accumulate funds for retirement

and the IRS is now permitting an increased percentage of contribution for older employees, as opposed to younger employees. The chart (below) indicates the differences of the traditional method of the consistent percentage of pay, with the integrated

Social Security formula (both of which have been approved for many years) and the new method which is referred to as an age-weighted average profit-sharing formula.

To determine which formula is the most attractive requires various calculations to determine the impact of the formulas. It is possible to utilize the new formula for Keogh Plans (HR10) and it is also suitable to use for corporate (PC) profit-sharing programs. The formula is not available on SEP plans. It is reported that 401K plans would also be eligible for the new profit-sharing formula. The only way to determine the best program is to run the calculations for all three plans based upon the

specific employees, their dates of birth and their annual earnings.

For help in preparing cost figures for your plan, contact Mr. Dick Martley, CLU, ChFC, at The Copic Agency. Phone 779-5455 or 1-800 421-1834.

*"...the IRS is now permitting an increased percentage of contribution for older employees. . ."*

Member	Age	Pay	Traditional Allocation Methods		Age-weighted Method***
			Pay to Pay*	Integrated**	
A	50	\$100,000	\$14,222	\$15,697	\$23,592
B	40	40,000	5,689	5,217	4,174
C	35	30,000	4,267	3,913	2,082
D	30	30,000	4,267	3,913	1,385
E	25	25,000	3,555	3,260	767
Total Contributions			\$32,000	\$32,000	\$32,000

\* A pay to pay allocation method gives each member a share of the total contribution based on a ratio of the member's pay over the total pay of all plan members.

\*\* An integration allocation method gives each member a share of the total contribution based on the member's pay, but gives higher-paid members a greater percentage of the contribution for wages above the current social security wage base.

\*\*\* "Age-weighted average profit-sharing formula"

# Six Honest Servingmen

by Myron L. Treber, Executive Vice President  
Your Personnel Manager, Inc.

Note: Mr. Treber is Human Resources consultant to Copic Insurance Company

**"Warning: RETIRED!**  
*Knows everything and has plenty of time to tell you about it."*

I saw a T-shirt the other day that said, "Warning: RETIRED! Knows everything and has plenty of time to tell you about it." It caught my attention, because my wife and I had just returned from a weekend in the mountains during which we did some pre-retirement planning with a little different twist. We spent our time answering the question, "What are we going to do when we retire?", not "How are we going to afford retirement?" Important as that question is, we had already spent time answering it and implementing our plan. What we need now is a plan on how to spend our time... not our money... in retirement. Spending money will probably take care of itself! And we don't want to fall into

the trap the T-shirt alluded to.

We spend a great deal of time and effort preparing ourselves for a lifetime of work. We spend 2 or 3 decades working in our profession or career. We may even engage the services of a financial planner to help with investments so we will have financial security when we retire. Unfortunately, most people give only cursory thought to what they will **do** when they retire,

Retirement is changing dramatically, and that's the reason it is so important to give thought to what you will do when you retire. Let's take a quick look at what is taking place.

There is a change in when retirement occurs, brought about by the "down-sizing" of so many organizations. As you know, it's not uncommon to hear of early retirement occurring at age 55 (or sooner) in some cases. That immediately adds ten years of retirement to the equation. Ten years is a long time when you are no longer employed or involved in your practice! Furthermore, the "golden parachutes" offered by some organizations to early retirees generally relieves them of immediate financial concerns.

There is also a change in when retirement occurs brought about by the high level of stress in today's workplace. Burnout is occurring at virtually every level within many organizations. And this results as well in individuals taking early retirement.

Then there's the fact that we are living longer. A quick glance at the *Ordinary Mortality Table* taken from

a publication of The National Underwriter Company indicates that, currently, a 55 year old male can expect to live to just over 76 years of age. A female of the same age can expect to live to over 80 years.

This means that if one took early retirement, he or she could expect to have between 20 and 25 years to fill with some meaningful activity. That's not many years less than a person would have worked!

In 1968, my father retired at age 65 after 50 years of working. Having his own business, retirement for him meant changing his work day from 10 to 12 hours to 4 or 5 hours. He did this for another 10 years and then finally quit working. He enjoyed a reasonably good quality of life for another 10 years, and died when he was 87.

The point is simply this. In many ways, my father's could be considered a "typical" retirement 25 years ago: work as long as you could, then retire and enjoy another 10 years or so. Yes, retirement has changed dramatically!

When answering the question, "What will I do when I retire?" I would suggest considering **Six Honest Servingmen** made famous by Rudyard Kipling's **The Elephant's Child:**

*"I keep six honest serving men,  
(They taught me all I knew),  
Their names are What and Why  
and When,  
And How and Where and Who."*





**W**hat... will you do? The typical answer I get when I ask this question is "I'm going to do all the things I couldn't do while I worked." A reasonable answer, I suppose, but not very realistic. There are only so many projects... so much fishing, golf and tennis... so much traveling you can do. Remember, if you retired today at age 55, you've got over 20 years to fill. Why not consider volunteering part of your time, using the skills you've acquired? There are numerous organizations (such as Rotary, Kiwanis and Lions) which have programs where your time could be put to good use. Churches, hospitals, mission organizations... all can use your skills. Or consider something entirely different from what you're doing today. A friend of mine is the Chairman of the Board of Trustees at his church. He retired a few years ago, and now spends 3 or 4 half days a week at church doing maintenance work and the like. A far cry from his management position where he travelled around the country conducting training classes.



**W**HY... are you considering retirement? People retire for many different reasons. They are tired of working, have reached age 65 and they're ready for retirement. They want to do "those things they've always wanted to do." Others are "burned out" in their present situation, so they retire. Unfortunately, many have given little thought to retirement and they have no idea how to spend their time. For many of these, life literally goes to waste. Then there are those who are forced into early retirement by their company or organization. They still have many years in which to be productive. These people need to give particular attention to answering the question of what to do. Other-

wise, they can easily fall into the trap of the "burned-out" person. Consider a person we'll call Fred. Fred is 56 years old and was recently asked by his employer if he was interested in early retirement. After working for the firm for 30 years, Fred decided to accept their offer. I was talking to him the other day, and asked how he was doing. He said he was really enjoying himself. He and his wife were travelling a lot, and he was getting caught up on several projects around the house. But when I asked him what his long range plan was, he had no answer. Knowing Fred, he will keep himself occupied... occupied, perhaps, but probably not very happily so.



**W**HEN... to retire is not always up to the individual. As mentioned earlier, "down-sizing" sometimes dictates the "when" of retirement. That's why I don't look at retirement as quitting work. Rather, I look on it as a career change. My "career" as a retiree will include writing and some volunteer work, along with some of the typical "retirement things."



**H**ow... you retire is up to you. You can either retire with a well thought-out plan, or you can retire and hope for the best. When we think of retirement in financial terms, we don't say "I'm going to retire and hope for the best." Rather, we carefully think through what are our financial needs so as not to burden others. We need to be just as sure we don't burden ourselves and those around us by depending on them to keep us occupied. Or, like the T-shirt suggests... knowing everything and having plenty of time to tell others about it.



**W**HERE... you spend retirement is another critical question. My wife and I have always planned on retiring to our home in Breckenridge. But a few weeks ago we had my mother up for the weekend. She's nearly 87 years old and in exceptional health. As I saw her struggle with just a short walk, I realized that while we may be able to retire there for a while, we will probably have to settle on another place in later years. My point is this: remain flexible... enjoy what you can when you can. Then be prepared to make adjustments as age, physical condition and other factors dictate.



**W**HO... should be considered as you contemplate retirement? Is your spouse ready to retire with you? Are your children raised? Do you have an aging parent to care for? Are there other individuals for whom you are responsible? As I talk to recent retirees, this is generally the last thing they think about. I'm not suggesting you build your decision to retire around all the people in your life; I am suggesting you give it appropriate thought and discuss your plans with them.



#### **WHO, WHAT, WHEN, WHERE, WHY AND HOW?**

These are six of the most important questions you can ask yourself as you contemplate retirement. Be sure to think through your answers carefully, develop your plan and then go ahead... enjoy your retirement to the fullest!

# Americans with Disabilities Act Update

by Joel M. Karlin, MD  
Alternate AMA Delegate

*"Unfortunately, our federal government has seen fit to interfere with our doctor-patient relationship"*

In accepting the trust society has placed in each of us when we became physicians, we have cared for all of our patients throughout time with caring, dignity and empathy. Unfortunately, our federal government has seen fit to interfere with our doctor-patient relationship, oftentimes to the detriment of our patients and our ability to provide such care. Although the intent of the newly enacted Americans with Disabilities law was noble, the posture recently taken by attorneys representing a segment of deaf patients created a potential schism in the doctor-patient relationship. After receipt of such information from one of our colleagues, the Colorado Medical Society House of Delegates, at the recent Interim session, passed a resolution to obtain legal advice for our physicians in complying with the new law. This information was printed in the May, 1992 issue of *Colorado Medicine*. Unfortunately, our attorney's advice still left the individual physician uncertain as to how to proceed. Your AMA Delegation took this issue to the just completed meeting of the AMA House of Delegates in Chicago. The House passed our resolution asking the AMA to provide physicians information required for compliance with the law. At the time of the AMA meeting, information was provided to us by the American Society for Physical and Rehabilitation Medicine. In a letter dated June 23, 1992, Mr. Dick Verville of the law firm of White, Verville, Fulton & Sanes of Washington, DC wrote the following:

Regulation 28 Code of Federal Regulations, §36.303 specifies a range of auxiliary aides and services covered by Act and it sets forth requirement that cannot deny service, segregate, or otherwise treat differently (regarding the service) because of lack of "auxiliary aids or services" unless the furnishing of aid or service would fundamentally alter the service or result in undue burden. Undue burden, similar to undue hardship in employment area, means *significant* expense or difficulty looking at overall financial available resources and number of people employed (28 CFR 36.104). The aid or service used needs to be "effective." The customer/patient should be consulted with *but* the regulation and legislative history are clear that the choice of what is effective is that of the public accommodation. The deaf specifically argued and lost the case that the aid or service reflect the express choice of the deaf person. The test is what is an effective communication that doesn't alter the nature of the service and is not an undue burden. The regulation states in the accompanying narrative that the "auxiliary aid requirement is a flexible one. A public accommodation can choose among various alternatives as long as the result is *effective communication*."

The list of auxiliary aids and services includes not only "qualified interpreters," but also "written materials, computer aided transcription services, video text displays." The regulation included



# How to comply

specific discussion of signage and health care. The Justice Department indicated that a note pad and written material were insufficient to permit effective communication in a doctor's office when the issue was "major surgery." In the final regulation, the Department of Justice said "other situations may require the use of interpreters depending on the facts where the matter might be sufficiently lengthy or complex but a terminal for type-written exchange may also be an effective substitute for a note pad.

**Conclusion:** The choice is that of the doctor as to what is an effective aide or service including handwriting, computer typing, and interpreters, but the method must be objectively "effective" and the Department of Justice indicates that note pads are not enough for matters like decisions about major surgery or similarly complex, lengthy and serious matters.

To me, clear, expeditious, written communication could be more effective than using a middle person because it is direct patient to doctor. The method of communication must also not alter the service fundamentally and not be an undue burden either in terms of expense or difficulty.

We are hopeful that between this most recent information and that information previously printed in *Colorado Medicine*, you will be able to deal more adequately with the provisions of the Americans with Disabilities Act. It is our hope that such a new law will not interfere with what has previously been caring service provided by physicians to all patients.

*\*Note: Because this is such a critical issue to Colorado physicians, we asked the CMS attorneys to comment on the material Dr. Karlin brought back from the AMA and to clarify Mr. Verville's statement that "the deaf specifically argued and lost the case that the aid or service reflect the express choice of the deaf person." Here is the reply by Karen B. Best, Esq., an Associate with Montgomery Little Young Campbell & McGrew, whose practice emphasizes health care law.*

"The choice is that if the doctor as to what is an effective aid or service..." If the question is whether the patient can, in the first instance, demand or require the doctor to provide a certain type of auxiliary aid or service, then Mr. Verville's conclusion is correct. The doctor may choose which auxiliary aid or service to provide; however, keep in mind that the patient can challenge the decision if he or she disagrees with the choice.

What happens of the disabled patient challenges the doctor's choice? The reviewing body will ask these questions: Did the doctor make the decision after consultation with the patient? The Act strongly urges consultation with the disabled person. What auxiliary aid or service, if any, would result in "effective communication" between the doctor and patient? The Act offers alternatives, ranging from note pads, typewriters or computer terminals, video text displays, written materials, and interpreters. Is the doctor required to provide the aid or service? Yes, so long as providing the aid or service would not result in undue burden in terms of either economic burden or practical feasibility, and would not fundamentally alter the nature of the service. If providing the aid or service would result in undue burden or fundamental alteration of the service, then the doctor is not required to provide the aid or service. However, if another non-burdensome means of effective communication is available it must be employed. Did the chosen aid or service result in effective communication between doctor and patient? If not, the doctor has violated the Act and will be subject to its penalties.

The bottom line is this: The Act does not require the doctor to adhere to a patient's desire or demand for a particular auxiliary aid or service. The doctor can make the choice; however, if challenged, a court could determine that the choice was wrong, that it resulted in discrimination, and that it was therefore in violation of the Act.

*The choice of aid or service belongs to the physician, but the method of communication must be effective and not discriminatory.*



# Communicating Environmental Risk

## Patients look to you for information

Risk is a part of everyday life. Health care providers discuss risk with patients, and public health officials promote programs to reduce the risk of disease and/or injury. Communicating about risk is an important tool in health care.

One of the concerns of the public is environmental hazards from chemicals, particularly the hazards from living or working near a hazardous waste site. The federal Agency for Toxic Substances and Disease Registry (ATSDR) estimates that 4.1 million people live within a

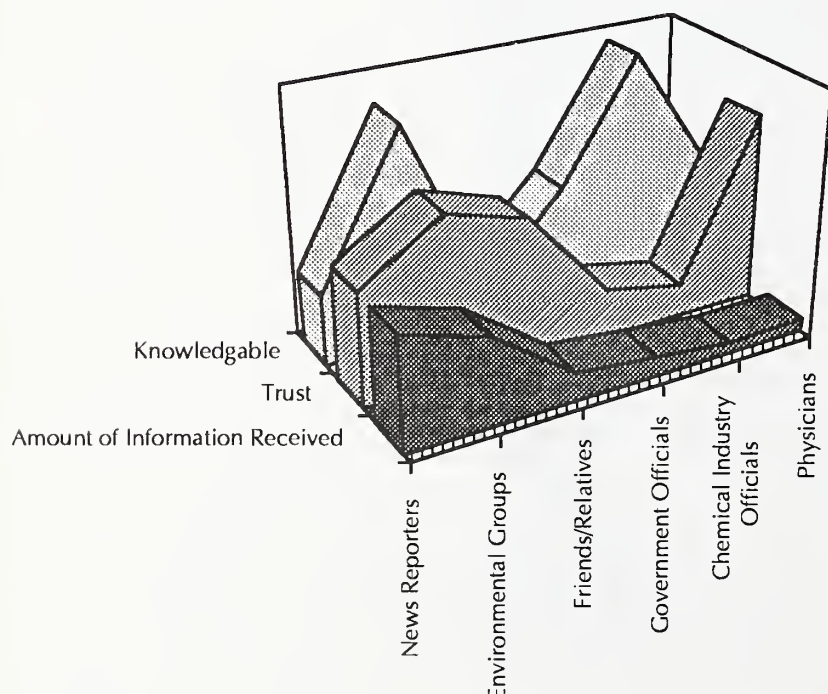
one mile radius of 725 National Priorities List (NPL) sites where population data were available. In Colorado there are ten Superfund sites in the Denver metro area; four mountain mining communities are the sites of heavy metal contamination; and two Superfund sites contain radionuclide contamination. Patients may bring to health care providers such questions as:

Is my water safe?

Are the cases of cancer in my neighborhood caused by toxic chemicals?

Will I get sick in the future because I live near a Superfund site?

Public health officials and environmental health specialists deal with the concept of an acceptable level of risk for exposure to a hazardous chemical. Regulatory agencies such as the Environmental Protection Agency (EPA) and Colorado Department of Health (CDH) use a risk assessment process to develop the levels of acceptable risk for Superfund site cleanup. The risk assessment process estimates the potential that a chemical can cause disease and determines if people are sufficiently exposed to the chemical to result in illness. These risk assessment numbers are derived from data that involves many assumptions and only estimate the likely health effects in a population. For example, a cancer risk of one in one million to one in ten thousand ( $10^{-6}$  to  $10^{-4}$ ) is used







Sallie Thoreson, MS  
Colorado Department of Health

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OF HEALTH

as the maximum risk at hazardous waste sites, and exposure to non-carcinogens should be below the hazard index determined for each chemical at each site.

Health care providers are then called upon to interpret or communicate this risk to their patients. The public is increasingly aware and concerned about hazardous chemicals. The combination of scientific technology, which has identified many environmental and health hazards, and regulatory programs such as Superfund, which are working to remediate the hazards, have heightened the public's awareness and often fear of chemicals. Information from the news media and government may confuse or frighten the public. Health care providers are seen as a highly credible source of information. According to a study sponsored by EPA in six US cities, health professionals received the highest trust rating but they are used by the fewest respondents as an information source, and they are seen as about as knowledgeable as news reporters on chemicals in the community.

Health care professionals will continue to get questions from patients. It may be frustrating for both the patient and the health care provider to discuss science in the context of exposure to hazardous substances. Some of the difficulties include:

- **Risk perception has many components**, in addition to the science of the numbers. For instance, the higher the perceived benefit from the risk, the lower the perceived risk. People generally view the risk as

higher when the hazard is forced upon them; is artificial, as opposed to naturally occurring; may cause a dreaded disease; or if the chemicals are unfamiliar or exotic substances.

- **There are limits to our knowledge.** Saying "I don't know" may be one of the most difficult risk communication lessons. For example, cancer risk is often based on animal testing in the absence of adequate data on humans. The effects of chronic, low levels of toxic exposure are often not clear. It may be possible to measure chemicals in the environment, but not possible to adequately detect the chemical in people.

- **The perception of risk can be quite different from the scientific risk estimate used by governmental agencies.** A one in a million risk of death may be acceptable as a cleanup standard, but to people living near a Superfund site this risk translates to one death. And similar to the lottery, the question may be "will that be me or my child?" A trusted health care provider may be able to explain that all people exposed to low levels of a cancer causing pesticide may have an increased risk of cancer, but that not every one exposed will develop cancer. Any cancer risk from the pesticide would be in addition to the 200,000 cases of cancer from other causes expected in a population of one million.

Health care providers need to follow the familiar steps of: history, physical examinations, appropriate laboratory tests, review of results, and therapy as needed. For chemical hazards, the involvement with the

## Superfund Sites in Colorado

### SOUTH ADAMS COUNTY

**Broderick Wood Products, Chemical Sales, Sand Creek, and Woodbury Chemical:** pesticides volatile organic chemicals (VOCs), heavy metals in soil and ground water.

**ASARCO-Globe:** heavy metals from cadmium smelter

**Rocky Mountain Arsenal:** pesticides, nerve gas, other toxins in soil and ground water

### DENVER METRO

**Rocky Flats (Golden):** Radioactivity, VOCs, heavy metals in soil, ground water

**Denver Radium (Denver):** Radon, radionuclides at 44 sites

**Air Force Plant PJKS (Jefferson County):** VOCs, rocket fuel in ground water

**Marshall Landfill (Boulder County):** VOCs, inorganics in ground water

**Lowry Landfill (Arapahoe County):** Chemicals, radionuclides in soil, ground water, surface water

### MINING SITES

**Eagle Mine (Minturn)**

**Smuggler Mine (Aspen)**

**Clear Creek/Central City/California Gulch (Leadville) and Idarado (Telluride/Ouray):** Lead, zinc, arsenic as by-products of mining and milling in soil in and water.

### OTHER SITES

**Lincoln Park (Cañon City):** Radionuclides, heavy metals in wells and ground water

**Uravan (Montrose):** Radionuclides, heavy metals in soil.

# Environmental Risk

*from previous page...*

**Who to call:**

**Colorado Department of Health (303) 331-4830**  
**Environmental Protection Agency (303) 294-1100**

patient will include communication about risk. This can start during the history taking when the practitioner inquires about environmental exposures, including questions about work, hobbies and the environmental surroundings, including location of hazardous waste sites in the neighborhood. A patient's concerns may be about symptoms or future health problems, but often the concerns include questions about declining property values, frustration at not being able to control the situation, or anger that a Superfund site is located in their neighborhood. Useful risk communication guidelines might include:

***Be careful about comparing chemical risks to more familiar risks.*** People get angry when Superfund risks are compared to the health risks of say, smoking, since smoking is a voluntary activity under individual control, versus the possibility of cancer from an abandoned waste site in the neighborhood. It is better to discuss the quantities of chemicals found, the risk levels for the individual chemicals and how this risk compares to other communities.

***Be sensitive to the issues that may be more important to people than the risk itself.*** Often the values and feelings need to be addressed first. A trusted physician can acknowledge the patient's concerns and fears and then discuss the actual risk information.

***Admit the uncertainty of risk assessment and the fact that there are limits to our abilities to diagnose and treat environmental illness.***

Patients generally want the health

care providers to run some tests to determine if exposure has occurred and to instigate appropriate treatment. This is difficult to do for most chronic low level exposures to chemicals. Treatment may actually involve discussing how the risk numbers are determined and what this means to the individual. It also means discussing health concerns when there are no tests or treatments available.

***Help patients locate a source of further information about chemicals and risk and ways they can become involved in the control of hazardous risks in their neighborhoods.*** The Superfund process includes a mechanism for individual involvement through community meetings, review of documents, and access to the decision making process. People are more comfortable about what is happening in the neighborhood if they have some control in input.

***Locate sources of information for health care providers to keep informed about the environmental health hazards that affect patients.*** The Disease Control and Environmental Epidemiology Division of the Colorado Department of Health has a program to provide health professionals with resources and information on environmental health hazards and patient management. This program is funded through a cooperative agreement with ATSDR.

For further information on the written materials or availability of seminars, contact Sallie Thoreson, MS, in the Grand Junction Regional Office, 222 S 6th St Rm 232 Grand Junction CO 81501, (303) 248-7161.





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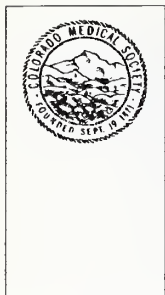
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# GET THE ADVANTAGE

## MEMBERS' LONG DISTANCE ADVANTAGE

*The Colorado Medical Society's Buying Power Pays Off For You*

As a member of CMS, you can now save up to 10% on all of your long distance telephone calls through our Members' Long Distance Advantage program. You'll receive guaranteed savings on every call plus the quality of the nation's only 100% digital fiber optic network with this new member benefit program.

### SUPPORT FOR CMS

Through this special program we are able to generate funds to support our goals and programs ... at no cost to you! Not only will you save up to 10% on your long distance bill, but you will also be supporting CMS with every call you make.

### COMPARE US TO ANY MAJOR CALLING PLAN AND SEE THE SAVINGS

We offer you significant everyday savings that can beat AT&T Reach Out America, MCI Friends and Family or any other nationally advertised long distance plan depending upon your calling patterns.

- Support CMS at No Cost to You
- Guaranteed Savings on *Every* Call
- No Monthly Charge
- No Cost to Join
- Free Calling Card Features Our Logo

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and Liz Leif, Consulting Actuary with Hewitt and Associates.

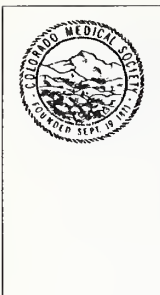
The class starts September 16 and runs on Wednesday evenings. Call 871-3155 for more details.

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William S. Pierson  
Managing Editor

*He tolled the bell, but did anyone respond? The revolt is no longer 'lying in wait.' It has arrived!*

*And...  
"Corporate Medicine" is back.*

The Denver Post Friday, Sept. 24, 1982

# Health-Care Cost Revolt 'Lying in Wait,' Says Lamm

## 'Corporation Medicine' Isn't Answer, Medical Society Told

By SHARON SHERMAN  
Denver Post Capitol Bureau

COLORADO SPRINGS — A citizen revolt against rising hospital and health insurance costs is "lying in wait out there," Gov. Dick Lamm told the Colorado Medical Society Thursday.

Lamm said government and the medical community need to work together to cure the "disease" of escalating health-care costs, but he warned that "corporate medicine" isn't the answer.

The Governor noted that angry taxpayers in California revolted by passing Proposition 13, and said a similar backlash to rising medical costs could occur in Colorado and elsewhere.

Although Lamm took pains to note that he wasn't giving a political speech Thursday, the governor is running for re-election and the Colorado Medical Society meeting at the Broadmoor Hotel was a desirable showcase.

Lamm opened his speech with praise for the society and its work on various laws. He also said twice, as he talked about rising health-care costs, that the doctors weren't to blame for the problem.

The governor said health-care facili-

ties are being purchased by large corporations at an alarming rate.

While such consolidation may lower costs in some instances, Lamm said, the trend is making health care an "economic entity (which is) moving away from community involvement."

Lamm warned that if hospital and physician corporations take over the health-care industry, small independent hospitals and independent doctors may be forced out of the system.

If that happens, he predicted, health programs for the poor may dwindle as the medical industry turns more and more to a concern for maximum profits and minimum losses.

The governor's Republican opponent, John Fuhr, later told The Denver Post in an interview that Lamm's attacks on corporate medicine don't offer any solutions to the problem of health-care costs.

Fuhr, a veterinarian, said he hadn't developed a specific plan of what he would do about that problem. But he said he would beef up the review process for health programs paid for by the government — such as Medicaid — so that those who truly need care are getting it and that waste is eliminated.





# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

1992

Volume 89, Number 10

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### Question

Can there be scientific order in development of a health care reform plan?

### This Issue:

- Health Care Reform: Questions for Patients, Physicians and Society ..... Leigh Truitt, MD, President, CMS
- Health Care Reform: A Vision for the Future ..... Sandra L. Maloney, Executive Director, CMS
- Health Care Reform: Plan Developed by the Colorado Medical Society ... Physician members and delegates
- Health Care Reform: Related to Education (letter to the Editor) ..... Donald G. Eckhoff, MD, Denver



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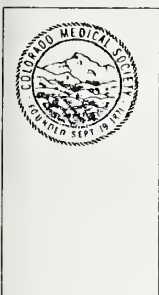
October, 1992

Volume 89, Number 10



## Cover Story

Colorado Governor Roy Romer sits in with CMS members to discuss education and health care reform. See articles on page 339 and following.



## DEPARTMENTS

- 339 President's Letter
- 347 Executive Director's Update
- 356 Proceedings of the House of Delegates
- 358 Delegate Attendance
- 361 Letters
- 368 Health Care Financing
- 370 Specialties
- 371 Board Highlights
- 374 Medical News
- 378 Ruminations
- 379 Classified Advertising

## In This Issue...

- 339 **Health Care Reform: Questions for Patients, Physicians and Society**

*Leigh Truitt, MD*  
*President, 1992-1993*

- 348 **Colorado Health Care Reform: the CMS Plan**

- 354 **Highlights of the Annual Meeting**

- 362 **Ambassadors of Science**

*Gil Maestas, II*

- 363 **Participation '92: How to get involved**

*Ben Galloway*  
*Patti Brown*

- 364 **On the Campaign Trail**

*John Elliff, MD*

- 365 **CMS Volunteer Judges at State Science Fair**

- 366 **Parent-Professional Partnership in Fremont County**

- 372 **Better Communication: Accent Modification**

*Michael P. Thompson*

- 377 **Cramped and Tongue Tied Writers**

*Thomas Coleman, MD*



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Leigh Truitt, MD  
President, 1992-1993

# Health Care Reform

## Questions for Patients, Physicians and Society

*(The following is the text of the inaugural address delivered by President Leigh Truitt, MD to the Annual Meeting of the Colorado Medical Society September 12, 1992.)*

I would like to thank you for the opportunity to serve you as President of the Colorado Medical Society this year. During the last year, our leaders held forums throughout the state to discuss health care reform. I would like to continue this timely theme by encouraging critical examination of health care in general and our role in particular.

There are aspects of our health care that do not meet expectations of quality, cost of access. You are familiar with the problems. Rather than discuss specific proposed solutions—play or pay, vouchers, single payor, universal health—I will suggest some questions that we must answer before we make choices. Some questions are obvious and others are not. From your answers, you may see the implications for the practice of medicine under each solution. We must ultimately achieve a consensus if we hope to participate in determining the course of health care reform.

**Is health care a right?** We have defined many rights beyond the "life, liberty, and the pursuit of happiness" in the Declaration of Independence. Some of these are in the Constitution and others in legislation. Health care is nowhere guaranteed as a right. There is also legal precedent to say that it is not.<sup>1</sup> Nevertheless, most of us believe that access to some sort of health care should be available to all.

This is one of those subtle questions. We all agree that anyone bleeding to death in the street should have access to life saving care. What we really need to ask ourselves is **should everyone have insurance coverage**, whether they pay for it or not? I believe in *universal coverage*, at least for a basic tier of health care.

For every right, there is an obligation. **Whose obligation is it to pay for health care?** Doctors and hospitals? The employer? Or society as a whole? When no one had insurance, providers of health care did provide care of the indigent by cost shifting to paying patients. Employers now fund most health insurance. However, we have decided that society should finance many services such as fire and police protection, defense, education, roads. If health care is a right, it is an obligation of us all.

Again, we should look deeper at the issues here. Should those who pursue unhealthy life styles be subsidized by those who try to preserve their health? The *Casualty Insurance Model* assumes that premiums can be set according to the expected loss, as in automobile, household, and life insurance.<sup>2</sup> Theoretically, such rate setting encourages healthier life styles and more cost conscious decisions about use of health care. However, there are problems such as pre-existing conditions, exclusions, and poor

*Is health care a right?*

*continues...*

# HEALTH CARE REFORM

*"[W]ith every grant of complete security to one group the insecurity of the rest necessarily increases."*

predictability. The alternative is the **Social Insurance Model**, with extensive cross-subsidization among different risk groups, ignoring expected losses in allocating costs. This brings some efficiencies in the form of lower administrative and sales costs since everyone participates. It also more fairly distributes the burden since no one can opt out and take their chances on a free ride.

33.6 million people were already covered in 1989 at a cost of \$98.3 billion by a single payor—the Federal Government—in an almost universal coverage, social insurance system for those over 65—Medicare.<sup>3</sup> Since 1965, health care has been de-stabilized by the enclosure and isolation of one segment of our society under Medicare and Medicaid. Those covered by private insurance have suffered tremendous inflation in health care costs. Others have no insurance at all. F. A. Hayek, the noted free market economist, deplored social planning except as a last alternative when a free market solution could not meet the need. In his words:

The reason for this is that with every grant of complete security to one group the insecurity of the rest necessarily increases. If you guarantee to some a fixed part of a variable cake, the share left to the rest is bound to fluctuate proportionally more than the size of the whole.<sup>4</sup>

Abolish Medicare? Unlikely! Place everyone under a single payor national health care system such as Medicare? Difficult and undesirable in this country with our existing health care system. Single payor

systems work most efficiently in countries, such as Canada and Great Britain, with *de facto* rationing as a result of severe capacity constraints. In the United States with its excessive capacity in hospital beds, diagnostic facilities, and specialists, health care inflation would accelerate without draconian utilization review and micro-management.

**Must everyone have the same health care?** You hear much about health care rationing, basic benefits packages, and prioritization. We accept that tiers in health care exist, based on fee schedules and free choice of physician. The Oregon Plan restricted "what" was provided—a limited benefit package or explicit rationing. However, we could also focus on "how" care is provided and "who" provides it. There is evidence that an organized primary care based system is cheaper. Free choice of providers with open access to specialists costs more.<sup>5</sup> Perhaps, instead of guaranteeing access to a basic benefits package provided anywhere in the system, we need to provide a basic system of health care.

Think of transportation. Some of us may drive downtown in a Mercedes. Others may arrive in a Ford Escort. Still others take a taxi. The lowest tier of transportation in Denver is the Regional Transportation District or RTD. We all arrive downtown. There is a difference in time, convenience and luxury. The cost also varies significantly. But the outcome is the same. The RTD is subsidized by society, although it is not free. We have decided that some form of public transportation is



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CMS Med Fax<sup>®</sup>

by *Montgomery Little Young Campbell and McGrew, P.C.*

legal counsel to the Colorado Medical Society

## HCFA Forces CFMC Cutbacks

Jack L. Berry, MD, President of the Colorado Foundation for Medical Care (CFMC), has announced the closure of CFMC's four regional offices by November 1, 1992. Dr. Berry said this move was caused by a Health Care Financing Administration (HCFA) move to reduce the level of funding the CFMC's six month extension of the PRO (peer review organization) contract for October 1, 1992 to March 30, 1993. In addition to the funding cutbacks, Dr. Berry said, HCFA has decreased emphasis on on-site reviews.

In order to operate under the decreased level of funding, CFMC was forced to consider drastic program changes, says Dr. Berry. The decision was made to close the regional offices in Colorado Springs, Grand Junction, Greeley and Pueblo. Nurse reviewers will be maintained in the regions and the closures will not

affect involvement of regional physicians, Regional Councils, or the communication network that CFMC has provided in the past. Administrative functions will be handled out of a centralized review program office located in Denver.

Dr. Berry said, "This type of change, as well as continued reduction in private activity, have brought to CFMC the hard recognition that a system put into place in 1974 needs to change due to the changing health care review environment." Dr. Berry wished to assure physicians that "CFMC plans to maintain its lead in providing the best response to HCFA's Scopes of Work. CFMC will use its knowledge of the Colorado health delivery system in order to be as well prepared for the future as possible."

For more information, contact CFMC at (303) 695-3300.

## Amendment 1 Alert!

Colorado Medical Society Members should carefully review Amendment 1- Constitutional Amendment Initiated by Petition, otherwise known as the Tabor Amendment By Douglas Bruce. If Amendment 1 were to pass this November 3, 1992 it could have far reaching ramifications regarding the ability to adequately fund state and local healthcare programs, including putting the state at risk in its ability to continue its participation in the Medicaid and the Medically Indigent programs.

If Mr. Bruce's tax limitation were to pass this November it would limit the annual growth in most state government spending to the rate of inflation plus the percentage change in state population. For the past five years the population growth and inflation has been: 3.3% in 1986-87; 2.85% in 1987-88; 2.2% in 1988-89; 5.2% in 1989-90; and 4.1% in 1990-91. Our state currently has spending limitations on general fund appropriations and a balanced budget mandate.

This proposal may be counterproductive to promoting the state's economic climate by limiting

government's ability to raise revenue and expend funds at those times when demands for government services increase. A prime example is the increased utilization of Medicaid resources and Medically Indigent funding.

Further restricting the legislature's ability to adequately fund healthcare programs, roads, education, and other services hinders government's ability to engage in those activities required for further economic development. Long-term uncertainty about Colorado's ability to adequately fund programs important to commerce and citizens will have a chilling effect on its business climate and may place low-income patients, and the hospitals, nursing homes and physicians that serve them at risk.

We urge you to contact the CMS Government Relations Department at 779-5455 or 1-800-654-5655 for copies of the 1992 Ballot Analysis prepared by the Council on Legislation. This Ballot Analysis contains arguments for and against all state ballot proposals. At this time, we urge you to formulate your own decision on this issue but strongly encourage you to carefully review the impact this Amendment could have on healthcare delivery in this state.

# CMS Med Fax

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

## **The Children's Hospital**

Colorado Alcohol & Substance Abuse Coalition  
Second Annual Regional Conference  
Prenatal Exposure To Alcohol And Drugs  
October 2-3, 1992  
Denver Colorado  
(303) 861-6946

## **Univ. of Calif. Med School Dept. of Radiology**

Radiology In Africa  
Nairobi, Samburu, Kenya, Masai Mara  
October 10-24, 1992  
Dawne Ryals (404) 641-9773

## **Lactation Program—Presbyterian/St. Luke's**

Contemporary Issues In Breast Feeding  
October 16, 17, 1992  
Radisson Hotel, Denver  
Elaine (800) 633-6824

## **Colorado Rural Health Resource Center & Consortium**

Colorado Rural Health: Creating Our Future  
October 16-18, 1992  
Glenwood Springs, CO  
(303) 331-8794

## **Rush-Presbyterian-St. Luke's Medical Center**

Rush Symposium on Hepatic & Biliary Disease  
Chicago, IL  
October 30, 1992

Suzanne Buss, (312) 942-6242

## **Medical Education Resources**

Asthma and Allergy in the 1990s  
Las Vegas NV  
October 30-31, 1992

(303) 798-9682 or 1-800-421-3756

## **Porter Memorial Hospital Foundation**

1992 Heart of Hearts Gala XII  
Hyatt Regency Tech Center  
Englewood Co  
November 21, 1992  
(303) 761-0186

## **Medical Education Resources**

Advances in Vascular Diseases

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

Asthma and Allergy in the 1990s

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

## **Radiological Society of North America**

78th Scientific Assembly & Annual Meeting  
Chicago, IL

November 27 - December 4, 1992

(708) 571-2670

## **Prosper Meniere Society**

Diagnostic & Rehabilitative Aspects of Balance & Movement Disorders

December 2-6, 1992

Denver, CO

Jane Wells (303) 788-4230

## **American Medical Association Hospital Medical**

**Staff Section Twentieth Assembly Meeting**

December 3-7, 1992 Opryland Hotel

Nashville, Tennessee

(312) 464-4754 or 464-4761

## **Medical Education Resources**

Coronary Heart Disease Update

Las Vegas NV

December 4-5, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

Asthma and Allergy in the 1990s

Key West FL

December 4-5, 1992

(303) 798-9682 or 1-800-421-3756

## **Medical Education Resources**

Asthma and Allergy in the 1990s

New York NY

December 11-12, 1992

(303) 798-9682 or 1-800-421-3756

## **University of Colorado School of Medicine**

Advances in Pelvic Surgery

Denver Co

December 11-12, 1992 CME credit

1-800-882-9153 or (303) 270-6761



# HEALTH CARE REFORM

necessary. In many countries, taxes on automobiles and gasoline are punitive, and public transportation is cheap and convenient.

We do not guarantee everyone a Mercedes because we cannot afford to. In health care, we cannot provide everyone with open access to specialty care, free choice of providers, single bed rooms and unlimited diagnostic testing. Unfortunately, we do not even guarantee everyone a ride on the health care equivalent of the RTD. In the future, I think we will.

## **Can only the government provide a basic tier of health care?**

Will only public facilities such as a Denver General or the Veterans Administration provide the guaranteed health care? Not necessarily. Most rural areas have a hard time supporting one health care system, let alone two. In metropolitan areas, if 40% of the health care market is in the basic tier, private providers will compete for this business. It will be difficult to run two systems, one competing with other providers for those who choose to pay for an upscale system, and one offering the basic tier. In time, small scale networks will probably specialize in one or the other. Large scale systems, that is, the General Motors of health care, may be able to do both.

**Will there be only one system of health care?** We in the United States are in love with health care. We are willing to spend 13% of our Gross National Product for the highest technology, most innovative, luxurious, patient friendly health care in the world. In the United Kingdom, Sweden, and other countries with

national health care, there exist private systems for those who wish to buy more convenience, shorter waiting times, and nicer hospital rooms. In these countries only a small percentage of the population opt out of the public system or basic tier. I see the majority of Americans paying extra for private health care.

**Can there be competition in health care?** I certainly hope so. My favorite thought is "Life is Capitated." This means that resources are limited and must be allocated—there must be "global budgeting" at some level. Someone must distribute resources. There are private, prepaid systems in existence that do this and do it well, efficiently and with high quality care. Those of us who practice in an uncoordinated, unorganized manner are at a competitive disadvantage. On the other hand, a public, globally budgeted system at a state or national level for all would be a mistake. Think of the Defense Department or Post Office! Auto manufacturers competing with one another offer a diversity of high quality vehicles with a rate of inflation less than the consumer price index.<sup>6</sup>

A few years ago, Garrett Hardin wrote about "The Tragedy of the Commons" in *Science*.<sup>7</sup> He was discussing population issues. Howard Hiatt later applied this concept to health care in *The New England Journal of Medicine* in "Protecting the Medical Commons: Who is Responsible?"<sup>8</sup>

In medieval England, every village had a *commons*. This was a large open field on which all of the villagers could graze their

*"Life is Capitated."*

# HEALTH CARE REFORM

*"Freedom in a commons brings ruin to all."*

livestock and farm in common. We have all seen the Boston Commons, a relic of this way of life. As long as the number of villagers and their livestock was such that the land could support this usage, all was well. As the population grew, however, each villager had a personal incentive to add another animal to his herd. And another; and another.... This is the conclusion reached by each and every herdsman sharing a commons. Therein is the tragedy. Each man is locked into a system that compels him to increase his herd without limit. Ruin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons. Freedom in a commons brings ruin to all.<sup>9</sup>

Hardin states that:

It is our considered professional judgment that this dilemma has no technical solution.

A technical solution may be described as one that requires a change only in the techniques of the natural sciences, demanding little or nothing in the way of change in human values or morality.<sup>10</sup>

Political solutions, that is, changes in human values and morality, as opposed to technical solutions, did occur. During the 17th and 18th centuries, improved methods of agriculture required more control over the land than the "old village system of open fields, common lands, and semicollective

methods of cultivation."<sup>11</sup>

The old common rights of the villagers were part of the common law. Only an act of Parliament could modify or extinguish them. It was the great landowners who controlled Parliament, which therefore passed hundreds of "enclosure acts," authorizing the enclosure, by fences, wall, or hedges, of the old common lands and unfenced fields.<sup>12</sup>

I see an analogy here to what is happening to us today. We have had a **commons** in health care upon which we all lived. The **commons** is no longer able to support the demands being made upon it. Certain of us are attempting to "enclose" part of the **commons** for ourselves — the good risks, the insured, the urban population. This "enclosure" leaves some out — the bad risks, the indigent, the rural inhabitants. Moreover, with the rise of PPOs, HMO's, and EPO's, not only patients but physicians and hospitals will be left out. The opportunity to provide care to certain patients is no longer available to all providers.

We have exhausted the technical solutions to this problem. Every sort of withhold, co-pay, deductible, risk arrangement, utilization review, and pre-certification has been tried. No improvements in underwriting, reimbursement schemes, organizational structures, or the like, will solve this dilemma. There will have to be a political solution — a method of allocation of resources that involves a consensus of providers and patients, supported by legislation.



# HEALTH CARE REFORM

Senate Bill 4 was passed by the Colorado Legislature and signed into law by Governor Romer this year. This proposes that Colorado study a political solution for the problems of health care access and cost control. This will be funded from a Robert Wood Johnson Foundation Grant and directed by the Governor's Office. We will determine the feasibility of enrolling all Colorado citizens each year in a limited number of health care programs. A combination of payroll and other taxes will be collected by the State and then paid to the sponsors of these health care programs on behalf of the enrollees.

The critical elements of this concept are:

- The number of provider health care systems will be **limited**, reducing the number of insurers or other provider systems from over four hundred to eight to twelve.
- Reimbursement will be **prepaid**, that is, the amount will be determined in advance, probably by an independent health care board.
- Reimbursement will be **capitated** — so much per member per month will be provided to the health care systems. The insurance sponsors or the providers will be at risk.
- Provider systems will be **community rated**. There will be a single premium for everyone, and the sponsors will have to take any Colorado citizen that signs up.

There will be no opportunity for underwriting or managing risk by limiting enrollment (this is social insurance).

- The program will be **universal**, except for Medicare, if appropriate waivers can be obtained for Medicaid and ERISA Self-Insured Trusts.
- Insurance will be **portable** and not linked to employment so that, no matter who the employer or where the place of employment, the insurance will always be in effect.

In the health care reform language of today, this is "managed competition." There is a single payor, the State of Colorado. However, that payor does not reimburse providers directly but through a limited number of sponsors and does not assume risk. The sponsors assume risk. Who may be a sponsor? Only someone willing and able to manage risk would want to be a sponsor.

Insurers assume risk. HMO's assume risk. They pass risk back to providers in the form of capitated reimbursement or withholds. They also manage risk by tightening their networks, by limiting or enclosing their panels of providers, and by better management of these smaller panels. ColoradoCare will hasten a trend to smaller, more tightly organized, closed panel provider networks in order to survive with prepaid, capitated reimbursement.

Large HMO's in Colorado would undoubtedly be sponsors under ColoradoCare. National insurers already in managed care would

*"We will determine the feasibility of enrolling all Colorado citizens each year in a limited number of health care programs."*

# HEALTH CARE REFORM

*"No country has a system without flaws, but most have a system with universal coverage."*

probably also sign up although this would require significant consolidation of their networks of physicians and hospitals. Some providers, meaning hospitals and physicians, might create their own networks for direct contracting. No matter what, we would see a significant expansion of "contract practice" —payment of a fixed fee per annum for all care.<sup>13</sup> Fee-for-service reimbursement would significantly decline.

HMO's, or contract practice, in the form of closed panel, prepaid, capitated health care, are not a new concept in the United States or internationally. Where there is true competition on the basis of price, this has been the usual solution. Even if the price is the same for all, the ability to manage costs at that price is a form of competition on price.

Physicians do not welcome competition on the basis of price in the form of contract practice. In countries that achieved a high percentage of HMO market penetration, medical associations have fought back on three issues:

1. The right of the patient to have free choice of physician.
2. The right of free entry for physicians, that is, access to all patients, and the establishment of tenure—the right to remain in insurance-covered practice unless some very grave breach of defined regulations has been proven before some tribunal.
3. The preservation of price discrimination according to the income group of the patient.<sup>14</sup>

There are those who believe competition and the market will distribute resources fairly among both providers and patients. We have only to look around us to see the failure of these mechanisms in health care. In fairness, we must recognize that the emergent nature of most health care needs and the distortions of insurance reimbursement mean that a true market does not exist. None of us — either as providers or recipients of health care —would like a competitive market with all care awarded to the lowest bidder.

**Do we want competition?** We must ask ourselves how will we choose. Do we want to be part of a network, a contract practice, a closed panel, and compete on price? Or do we want to accept a fee schedule, utilization review and micro-management, and then compete by other means?

Throughout the world, societies are examining the costs of health care. The United Kingdom, with a national health care plan costing a very low percentage of GNP, is introducing a competitive market to some aspects of health care. Careful analysis of the single payor Canadian system suggests that there would not be substantial savings if that were instituted here.

No country has a system without flaws, but most have a system with universal coverage. Ask yourselves these questions. Your answers may differ from mine. Your answers will define the system that you think best. You may, for example, choose between a single payor with access to all patients and "managed compe-



# HEALTH CARE REFORM

tion" with loss of free entry to practice.

We are faced with political solutions such as ColoradoCare. If we are to be significant players in the new game, we must understand that we must make choices. Those choices will have profound implications for the future of medical practice. Let us choose in the best interests of our patients, the future members of our profession, and society as a whole.

In closing, I bring to you a famous quotation that seems appropriate for a medical society that hopes to speak for all those in need of health care and for all physicians:

No man is an island, entire of itself; every man is a piece of the continent, a part of the main; ... any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.<sup>15</sup>

As the Colorado Medical Society we must strive to protect the interests of all —patients, physicians, and society.

American Health Care System," *Journal of the American Medical Association*, 267: 1665-1666, March 25, 1992.

<sup>6</sup> Regina Herzlinger, "Healthy Competition: A third approach to the medical-insurance crisis," *The Atlantic Monthly*, pp. 69-81, August, 1991.

<sup>7</sup> Garrett Hardin, *Science*, 162:1243-1248, December 13, 1968.

<sup>8</sup> Howard H. Hiatt, *The New England Journal of Medicine*, 293:235-240, July 31, 1975.

<sup>9</sup> Hardin, p. 1244.

<sup>10</sup> Hardin, p. 1243.

<sup>11</sup> R. R. Palmer, Joel Colton, *A History of the Modern World*, (New York: Alfred A. Knopf, 1984), p. 428.

<sup>12</sup> Palmer, p. 428.

<sup>13</sup> Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, 1982), p. 63.

<sup>14</sup> Brian Abel-Smith, "The Rise and Decline of the Early HMOs: Some International Experiences," *The Milbank Quarterly*, 66:694-719, 1988.

<sup>15</sup> John F. Sheils, Gary J. Young, and Robert J. Rubin, "O Canada: Do We Expect Too Much from Its Health Care System," *Health Affairs*, 11:7-20, Spring, 1992.

<sup>16</sup> John Donne, *Devotions upon Emergent Occasions*, 1624.



## OTOLARYNGOLOGY UPDATE for PRIMARY CARE PHYSICIANS

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Course Directors, Paul H. Dragul, M.D. or Alan F. Lipkin, M.D.  
950 E. Harvard Ave., Suite 500, Denver, CO 80210.  
(303) 744-1961

<sup>1</sup> William J. Curran, "LAW-MEDICINE NOTES: The Constitutional Right to Health Care. Denial in the Court," *The New England Journal of Medicine*, 320: 788-789, March 23, 1989.

<sup>2</sup> This discussion is based on Victor R. Fuchs, "National Health Insurance Revisited," *Health Affairs*, 10:7-17, Winter, 1991.

<sup>3</sup> *Statistical Abstract of the United States 1991*, Table 145, p. 96.

<sup>4</sup> F. A. Hayek, *The Road to Serfdom: A classic warning against the dangers to freedom inherent in social planning*, (Chicago: The University of Chicago Press, 1944), p. 128.

<sup>5</sup> Roger A. Rosinblatt, "Specialists or Generalists: On Whom Should We Base the

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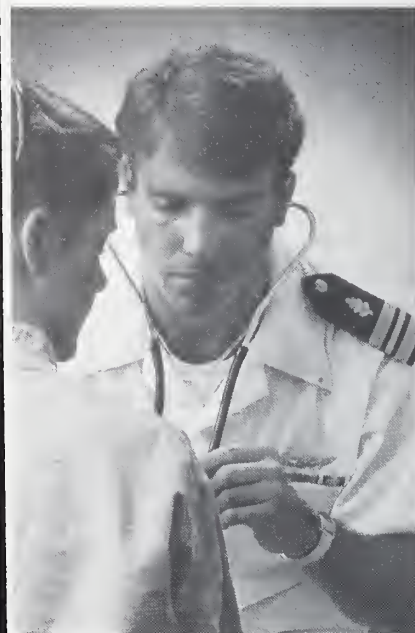


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## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director

The 122nd Annual Meeting is now history, and I think it will make the history books as an outstanding meeting. There are several reasons for my conjecture.

First, the meeting proved that when CMS leadership and members are given a challenge as major as health care reform, the system still works. Following nearly nine months of gathering opinion and discussion on the issues, the House of Delegates proved itself by bringing to agreeable conclusion a reform proposal that met with the majority opinion of the physicians. Dr. Butler successfully took the issues to the membership through the long series of meetings around the state and brought these issues to the House where, after serious debate in the reference committee, they were formed into a solid representative resolution. Yes, after laboring for nine months, we delivered a healthy product!

As a result of this resolution there should be no question in the mind of the Governor that physicians will be at the table to work out a Colorado health care plan.

Second, there was much discussion about the matter of whether a person can be invited to speak before this House, on issues not pertinent to the proceedings, without the membership's majority approval. Such was the case with the President-elect inviting Governor Roy Romer to speak to the House concerning his "Children First" initiative involving raising the state sales tax for education. Dr. Leigh Truitt brought this matter to the executive committee and it was then referred to the Board. After much discussion, the Board grudgingly approved and

the Governor was added to the House agenda for Sunday morning, September 13. It didn't stop there; the matter was brought up in the Constitution/Bylaws/Board of Directors Reference Committee on Friday and a serious debate followed. The matter was referred back to the House and the House went into executive session on Sunday morning to settle the matter.

In a nutshell, the subject boiled down to the fact that 1) the House of Delegates still establishes policy for this organization, 2) the Board of Directors sees to the administration of that policy, 3) the President or President-elect (or any other member) can still make recommendations to the Board, but when it is a precedent-setting question, the House of Delegates is the body that will make the policy decision.


This may sound like a large flap over a small matter (don't tell the Governor I said that), but it truly wasn't. It was an issue of democracy in which the society's system of governance was questioned... and the question was properly answered in the majority voice. This is why the system is still good.

Third, large discussion over small words; that is to say, the floor debate on wording of resolutions can be tiring, especially to the outsider, but when it is all boiled down it means that the total membership... every individual... has a voice in what this whole society says and stands for.

Yes, the system still works, and very effectively. You'll hear more about it in other reports and other actions in coming months. If you missed the meeting, I'm sorry. You missed a very good meeting.

*"[W]hen it is all boiled down it means that the total membership... every individual... has a voice in what this whole society says and stands for."*

**H**  **EALTH**

**C**  **ARE**

**R**  **EFORM**

## Scientific Order

### Factoring

#### If:

HCR = Health Care Reform

P<sup>la</sup> = The Players (CMS Members)

P<sup>ro</sup> = The Program (CMS Proposal)

CoCa\* = The Governor

100\*\* = Constant (100 Colorado General Assembly members)

CC\*\*\* = The Citizens of Colorado

CHIP = Colorado **H**EALTH **I**NSURANCE **P**ROGRAM

### Equation

#### Therefore:

$$(P^{la} + P^{ro} / (CoCa / 100 - CC)) = \text{CHIP (HCR)}$$



### Question

Can there be scientific order in development of a health care reform plan?

### Summary

The only known factor in the equation is the expression by the CMS House of Delegates, on following pages. The rest of the factors are fluid.

\* "Colorado Care"

\*\* Colorado General Assembly's disparate votes means there is a constant of 100 separate and distinct opinions about "health care" based on each legislator's constituency.

\*\*\* Each citizen also has an opinion of what health care should be.



# Colorado Health Care Reform

Prepared By CMS Board of Directors, August 21, 1992

Approved by the CMS House of Delegates, September 13, 1992

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## PREAMBLE

The Colorado Medical Society (CMS) believes that a universal health insurance proposal is needed which would provide coverage for all Coloradans. Benefit packages would be provided by private insurers, who would bear all financial risk for covered services. The program would be financed by multiple sources and privately administered. The goal of health care reform must be to allow all residents access to the most appropriate site of care.

In developing the following statements, CMS has taken into consideration what it believes are a number of fundamental issues that should underscore the discussion on improving the health care system. We have identified six basic categories, 1) Benefit Package, 2) Funding, 3) Administration, 4) Quality Control, 5) Cost Control, and 6) Externalities. Each of these categories is listed below, followed by the relevant specific points which build upon each category. These points are designed to accomplish the goal of expanding access to affordable quality health care to all Coloradans, to preserve the strengths of our current system, and most importantly, to remain as patient advocates rather than as agents of the government or other third parties. Some elements require further developmental work, e.g., definition of a basic benefits package. This work will be continued by the CMS Board of Directors and/or the House of Delegates as appropriate.

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## BENEFIT PACKAGE

**UNIVERSAL COVERAGE:** All Colorado residents should be assured of affordable coverage of their appropriate health care costs. The term "resident" must be precisely defined, and then extend the coverage to all residents, regardless of whether they seek the benefit or not. Such definition must include solutions to the difficult questions of part-time residents, transients, new residents, residents whose employers are located out-of-state, federal employees, and residents who are difficult to identify because they file no regular forms with a state agency. Attention must be paid to those individuals moving to the state for the purposes of obtaining health care coverage.

**BASIC BENEFITS:** The identification of a basic core of minimum benefits to be available to all Colorado residents is a necessary element in any comprehensive health system reform. The package should include the following:

*Preventive Medicine:* Coverage for preventive medicine should be emphasized and included. Preventive medicine would include but not be limited to prenatal care, immunizations, well-baby care and routine screening.

*Multi-Tier System:* A multi-tier system should be made available. This system would provide for a basic benefit package for all Coloradans with an option for the citizens to purchase, with their own funds, additional benefits.

**"We must ultimately reach a consensus if we are to achieve health-care reform. If we are to be included, we must understand that we must make choices."**

*Leigh Truitt, President  
Colorado Medical Society  
1992-1993*

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*Freedom of Choice:* Discussion on this topic centers around two fundamental issues. A cornerstone in our current system is the individual patient's freedom of choice to select his or her own physician and to pursue services which meet his or her health care needs. Freedom of choice can also be defined as the right of any physician, who meets the requirements of any authorized plan, to participate in that plan. CMS is concerned about physicians being inappropriately excluded from participation in plans.

*Portability:* It is imperative that employees be allowed to keep their coverage if they move from job to job within the state. Any plan, however, should include definitions for the treatment of coverage when residents travel out of the state. The treatment of employees of interstate business must also be addressed.

*Pre-existing Conditions:* The current insurance industry practice of excluding coverage to individuals because of pre-existing conditions must be eliminated.

## FUNDING

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The Colorado Medical Society is very concerned about the ability to achieve appropriate and adequate funding for any health care reform proposal. Any universal health plan should cease to exist if it operates on a deficit budget. There are uncertainties as to the level of taxation and the kind of taxes to be used as the revenue sources. We must know more about costs before we can assume that any health care reform proposal will work well.

CMS believes that a universal health plan for the citizens of Colorado must address the Medicare eligible population, Medicaid, automobile insurance, Workers' Compensation, and other coverage.

**IMPLEMENTATION:** CMS encourages an incremental implementation (phase-in) of any health care reform proposal.

**HEALTH INDIVIDUAL RETIREMENT ACCOUNTS (IRAs):** The tax code should be amended to allow for penalty-free and tax-free health IRAs and basic health insurance premiums.

**"SIN" TAXES:** The federal government must stop subsidizing the tobacco industry. Colorado must place extra taxes on alcohol and tobacco. These funds would be used to off-set the cost of a universal health care plan.

**MULTI-SOURCE REVENUE BASE:** Funding for any proposal should not fall directly on any one group, especially the employers. There must be a broad base of revenue sources. These revenue sources may include existing state and local medically indigent funds; employer and employee payroll tax; a new tax on cigarettes and alcohol; federal matching dollars to pay for care for those under 100% of the federal poverty level; and Medicare trust funds.



**"We've got to find a way to reduce the administrative costs of this. We must restrain these costs. How do we restrain these costs?"**

*Governor Roy Romer  
September 13, 1992*

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## ADMINISTRATION

**ADMINISTRATIVE COSTS/HASSLES:** Administrative costs must be made reasonable. A universal claim form must be implemented. This would include establishing uniformity in the requirements for submitting electronic claims. CMS supports a move toward a paperless system. A single procedural coding system must be implemented by all third party payers. Utilization controls should be uniform and periodically evaluated for demonstrated effectiveness. Purchase of optional supplemental coverage from the same insurance company would be encouraged.

**MULTI-PAYER SYSTEM:** CMS does not support the concept of a single payer or the limitation in the number of payors. CMS believes that the individual is responsible for selecting a plan that will meet his/her needs. The marketplace should determine the number of payors. The role of state government should be to insure the compliance with regulations.

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## QUALITY CONTROL

**OUTCOME RESEARCH:** The provision of medical care should be based on outcome research and the application of continuous quality improvement techniques. Quality care should conform to standards developed by, and acceptable to, the medical profession.

**MEDICAL ETHICS:** Physicians should continue to practice in accordance with the highest ethical standards. CMS encourages physicians to continue to treat their patients as individuals and to use their best professional judgment in every case.

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## COST CONTROL

The Colorado Medical Society understands the need for cost control. We also recognize that the patient has a responsibility in cost control, techniques of which may include co-payments, deductibles and education. We do not believe that inconvenience or administrative delay of the patient or physician is appropriate cost control. Methods of cost control may include the following:

**REIMBURSEMENT:** CMS supports the establishment of a uniform, statewide, resource-based relative value schedule. The reimbursement levels would be negotiated and agreed upon periodically by physicians. The physicians' ability to balance bill should continue to be an accepted practice provided patients are informed in advance. It is imperative that insurance payments be made directly to the provider, not the patient.

**MEDICAL VERSUS "SOCIAL" COSTS:** Study should be given to a rational policy for long term domiciliary care. One suggestion is that coverage be provided for the medical/nursing component of domiciliary care, whether delivered as home care or as nursing home care. The room and board component, whether delivered as home care or as nursing home care, could then be financed through other social agencies.

**"I think that there's excessive costs in our medical malpractice system. I'm ready to abolish the whole damn thing if somebody can get me an alternative to it."**

*Governor Roy Romer  
September 13, 1992*

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**HEALTHY LIFESTYLES:** Patients/consumers should be provided incentives and disincentives based on their lifestyles. Co-payment amounts should vary according to lifestyles. For example, patients who smoke should be required to pay a higher co-payment amount. Emphasis must be placed on the individual's responsibility for his or her own health.

**APPROPRIATE LEVELS OF CARE:** Physicians and patients must continue to be educated on the appropriate use of medical care. Cost-conscious decisions must be made by both physicians and patients.

**ADVANCE DIRECTIVES:** CMS believes that the use of advance directives should be expanded. To accomplish this, physicians and consumers must be provided with educational opportunities to learn more about the appropriate use of advance directives.

**EQUIPMENT AND PHARMACEUTICAL COSTS:** Methods of controlling the costs of durable medical equipment, medical supplies and pharmaceuticals must be devised.

## **EXTERNALITIES**

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**PROFESSIONAL LIABILITY:** CMS strongly encourages continued strengthening of Colorado's tort reform laws and other alternative dispute resolution procedures. This might include further study of reduction of medical liability premiums, the elimination of contingency fees, the impact of "defensive" medicine, and establishing an administrative versus tort system. We must be aware that national tort reform may not improve what we currently have in our state.

**HEALTH EDUCATION:** We must emphasize health education of the public to include the hazards of substances known to be harmful to public health. Also included could be K-12 comprehensive health curriculum to promote healthy lifestyles. CMS will continue to promote programs to eliminate smoking, discourage alcohol and drug abuse, reduce cholesterol, encourage better adolescent health, and other similar programs that are all aimed at improving health and reducing costs of health care.

**ANTI-TRUST LAWS AND REGULATIONS:** Appropriate peer review activities must be protected from anti-trust litigation. CMS supports revision of anti-trust laws and regulations to allow the negotiation and review of fees. Other revisions should be made to allow cooperation between health care providers to improve quality and/or reduce costs, e.g., to avoid duplication of services.



"I am respectful enough of the difficulty and the complexity of the problem that we have to have the very best minds of Colorado on it, and we must include all those who are critical to its execution: those of you who are providing these services."

Governor Roy Romer  
September 13, 1992

## CONCLUSION

CMS believes that a statewide dialogue must take place to address the challenges and critical issues regarding health care reform. The problem facing the health care system cannot be solved by any one organization. A collaborative process should be pursued. CMS is committed to the process of debate and discussion. Colorado physicians are committed to delivering quality care and want to work with other decision-makers toward positive solutions.



Colorado Governor Roy Romer joins CMS members at the Annual Meeting, September 13, 1992.

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LOCAL STAFFING NETWORK



# Highlights of the 1992 Annual Meeting

Photos by Gil Maestas, II

**E. Haavi Morreim, PhD** was one of the many highlights of the 1992 Educational Program. Her keynote speech and her part in the sessions on Medical Ethics were well received by all attendees; so much so that she was roundly applauded when introduced to the crowd at President Leigh Truitt's inauguration. She got to be on a first-name basis with fellow Scandinavian Sandi Maloney and was constantly surrounded by a cloud of admiring questioners.

A letter from Brad Darley illustrates the reception afforded this year's educational efforts: "The Delegates of the Arapahoe Medical Society heartily commend the CMS staff, physician leadership and participants in Saturday morning's educational program at the CMS Annual Meeting. The program was by far the best program in memory. Congratulations!"



**A. Lee Anneberg, MD**, President of the Denver Medical Society, presents DMS Past President **Wm. Carl Bailey, MD** to outgoing CMS President, **Harrison G. Butler, III, MD** and the House of Delegates after Dr. Bailey's selection as CMS President-Elect. Yes, Dr. Bailey informed the CMS staff at his first meeting with them, he is quite familiar with a certain old song, but looks forward to a fruitful term.



## Awards

**Robert McCartney, MD** was presented with the Colorado Medical Society Certificate of Service, the highest award given to a physician member by the society, for his industrious work on behalf of patients and the medical profession.

**Edie K. Register** was named CMS staff member of the year for her salutary work as Director of Health Care Financing.

Both Dr. McCartney and Ms. Register have demonstrated their expertise in interpreting and even *explaining* Medicare regulations.







## Community Service and Science Education

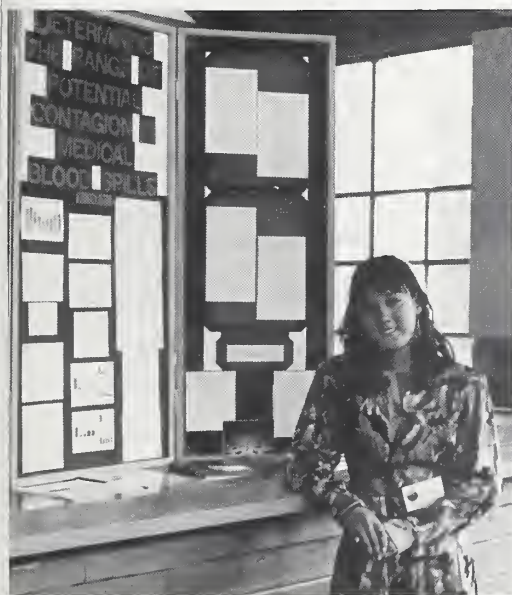
**H. Calvin Fisher, MD** was honored with the A. H. Robins Award for community service by a physician by the Wyeth-Ayerst Company. **Beth Osthmund** of Wyeth-Ayerst joins CMS President **Harrison G. Butler, III, MD** in presenting the award, which was accepted on Dr. Fisher's behalf by **John Muth, MD**, President of El Paso County Medical Society. Dr. Fisher resides in Colorado Springs.

Dr. Butler said, in a letter to Dr. Fisher, "Your contributions to the Colorado State Science Fair in the name of the medical profession is an outstanding accomplishment and you have graciously shared that credit with other physicians



by working on their behalf to encourage the young people in their pursuit of the natural and mechanical sciences. If it weren't for your many years of volunteer effort and devotion to the Science Fair I feel sure the Science Fair would be a thing of the past. I have heard many stories of your experience in guiding this program and keeping it in existence while maintaining the support of so many others, including the Colorado Medical Society."

Here, Dr. Fisher was photographed while serving as one of several volunteer judges representing the Colorado Medical Society at the Colorado State Science Fair in Fort Collins. (Photo by Bill Pierson, *Colorado Medicine*)



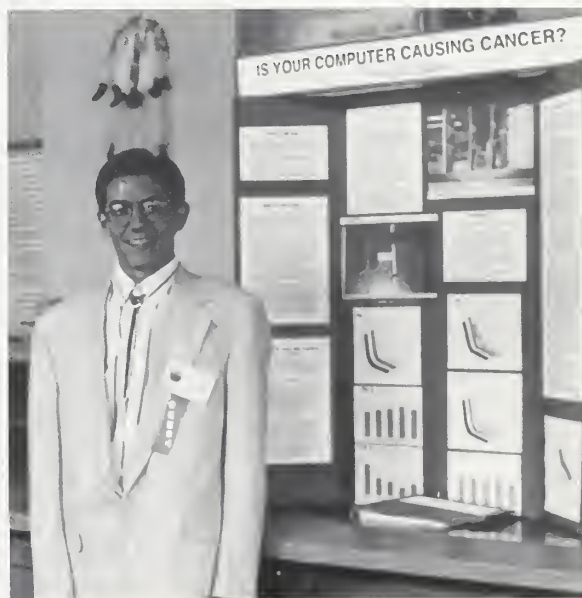
Each year, the Colorado Medical Society honors the winners in the Junior High and Senior High medical categories of the State Science Fair and invites them to display their projects at the Annual Meeting.

**Warren Gasper** of Fort Collins examined the relationships between radiation generated by Computer Display Terminals and incidence of cancer among computer users.

**Diann E. Miyake** of Englewood researched the possible contagion that might result from spills of blood or blood

products associated with medical facilities.

Both winners were presented with Savings Bonds and given the opportunity to display their research projects in the Registration Area of the Conference Center in order to discuss their research with the physicians in attendance. This is part of the medical society's attempts to promote science education and awareness.



# 122nd Annual Meeting

## Proceedings of the House of Delegates

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*The Colorado Medical Society House of Delegates met at the Copper Mountain Resort Center, Copper Mountain, Colorado, on September 11-13, 1992 and took the following actions:*

### REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BYLAWS

**Adopted** a Resolution which calls for the removal of any reference to gender in the Colorado Medical Society Bylaws.

**Adopted** a Resolution which asks that the American Medical Association explore the feasibility of redesigning Federal medical education loan programs to include the option of serving in rural areas to help reduce the indebtedness.

**Adopted** a Resolution to undertake the legislative action necessary to increase the cap on the surcharge that funds the Physician Peer Health Assistance Fund to \$25.

**Adopted** a Resolution for the Colorado Medical Society to study ways and means of decreasing the cost of a medical education.

**Adopted** a Resolution to change the Colorado Medical Society Bylaws to allow those members who are serving as AMA Delegates and Alternates to be also allowed to serve as Officers of the Society.

**Adopted** a Resolution to increase the Medical Student Component Dues to \$20.

**Adopted** a Resolution for the Board of Directors to determine the amount of dues paid by Active Emeritus Members who elect to receive *Colorado Medicine* and other CMS mailings.

**Adopted** a Resolution establishing guidelines for Health Care Reform which would be supported by the Colorado Medical Society.

**Adopted a Resolution changing the Bylaws** to allow for the formation of an Executive Committee for the Council on Ethical and Judicial Affairs.

**Accepted** for filing:

- Progress Report - Board of Directors
- Progress Report - Executive Director
- Progress Report - AMA Delegation
- Progress Report - Grievance Review Committee
- Progress Report - Physician Health Issues Committee
- Progress Report - Women in Medicine Section

### REFERENCE COMMITTEE ON LEGISLATION/PROFESSIONAL EDUCATION

**Adopted** a Resolution stating the CMS strongly oppose any state legislation or constitutional amendment which would legalize marijuana.

**Accepted** for filing:

- Progress Report - Council on Professional Education
- Progress Report - Council on Legislation
- Progress Report - COMPAC

### REFERENCE COMMITTEE ON COMMUNITY HEALTH ISSUES/MEDICAL SERVICE

**Adopted** a Resolution which sunsets current policy on HIV Infection in Health Care Workers and provided a revised version.

**Adopted** a Resolution to encourage medical schools, residency training programs, specialty boards, medical societies and medical group practices to develop parental leave policies.

**Adopted** a Resolution that representatives of the Colorado Medical Society meet with the Board of Medical Examiners and Nursing to develop comprehensive guidelines for the oversight of all non-physician medical providers in Colorado.



# Proceedings of the House of Delegates

## REFERENCE COMMITTEE ON COMMUNITY HEALTH ISSUES/MEDICAL SERVICE

(Continued)

**Adopted** a Resolution that the Colorado Medical Society provide information regarding persons who are qualified to conduct mock office inspections in preparation for OSHA inspections.

**Adopted** a Resolution to support all efforts to make Colorado tobacco free, including the passage of legislation which would ban the sale of tobacco products in vending machines.

**Adopted** a Resolution that the Colorado Medical Society should participate as the voice of organized medicine in appropriate discussions on practice parameters/guides.

**Adopted** a Resolution to recommend to legislators that the Colorado State Capitol Building be declared smokefree.

**Adopted** a Resolution that reaffirms the need for adolescents to receive confidential care consistent with their developmental and physical needs.

**Adopted** a Resolution for the Colorado Medical Society to encourage communities and responsible government agencies to develop guidelines and techniques to use advanced technologies to discourage, eliminate or replace high-speed chases by law enforcement officers.

**Adopted** a Resolution that the Colorado Medical Society support efforts to pass increased excise taxes on tobacco products.

**Adopted** a Resolution that the Colorado Medical Society call upon Congress to ensure that safety considerations are given prominent attention and high priority throughout CAFE policy debate.

**Accepted** for filing:

Progress Report - Council on Community Health Issues

Progress Report - Council on Medical Service

## REFERENCE COMMITTEE ON PHYSICIAN/PATIENT ADVOCACY

**Adopted** a Resolution proposing several recommendations intended to improve and encourage the line of communication between insurance companies, physicians and patients as well as establishing parameters which would regulate insurance companies more stringently and protect patient and physician rights.

**Adopted** a Resolution that the Colorado Medical Society encourage the American Medical Association and other state societies to use every means available to force HCFA to divulge the actual financial information used to determine the conversion factor for Medicare.

**Adopted** a Resolution that the Colorado Medical Society be a leader in efforts to correct the unreasonable reduction in reimbursement created by the "lesser of" provision of HB 1306 involving Medicare/Medicaid patients.

**Adopted** a Resolution that the Colorado Medical Society urge its legislators to support H.R. 4507 and S.2362 to repeal the reduction of Medicare Payments for new physicians.

**Adopted** a Resolution that the Colorado Medical Society supports the AMA policy that medically necessary referrals by a physician to an off-site facility in which the physician has a financial interest is ethical if the patient is fully informed of the ownership interest as well as the existence of any available alternate facilities.

**Adopted** a Resolution that the Colorado Medical Society work with all appropriate entities to develop guidelines for a standardized system of verifying eligibility for health benefits.

**Adopted** a Resolution that the Colorado Medical Society use all the means at its disposal to reverse the policy of automobile insurance companies using the Colorado Workers' Compensation RVS as the method of payment for medical care rendered as the result of non-work related automobile accidents.

**Accepted** for filing:

Progress Report - Council on Physician/Patient Advocacy (PPAC)

RES-59-P - Certain Sections - PPAC report on Managed Care

# Delegate Attendance – 1992 Annual Meeting

LEGEND (D) Elected Accredited Delegate (A) Elected Accredited Alternates (A\*) Substitute Accredited Alternates

## DISTRICT I - 5 DELEGATES

### Eastern Colorado - 1 DELEGATE

(A) Olson, Mark R.

### Morgan - 1 DELEGATE

(D) Thompson, Patrick L.

### Northeast Colorado - 2 DELEGATES

(D) Yu, Vincent T.

### Washington/Yuma - 1 DELEGATE

None Present

## DISTRICT II - 6 DELEGATES

### Intermountain - 2 DELEGATES

(D) Armour, Ross W.

### Lake - 1 DELEGATE

None Present

### Mount Evans - 1 DELEGATE

None Present

### Mount Sopris - 3 DELEGATES

(D) Painter, M. Ray

## DISTRICT III - 12 DELEGATES

### Northwestern Colorado - 2 DELEGATES

(A\*) Rathe, Laura E.

### Chaffee - 1 DELEGATE

None Present

### Fremont - 2 DELEGATES

(D) Buglewicz, John V.

### Huerfano - 1 DELEGATE

None Present

### Las Animas - 1 DELEGATE

(D) McFarland, Douglas M.

### Otero - 2 DELEGATES

(D) Morse, Jeffrey M.

(D) Berg, Mary Jean

### San Luis Valley - 2 DELEGATES

(D) Firth, Michael G.

(A) Brownrigg, Richard L.

### Southwestern Colorado - 1 DELEGATE

None Present

## DISTRICT IV - 6 DELEGATES

### Curecanti - 2 DELEGATES

(D) Hopple, Lynwood M.

### Delta - 1 DELEGATE

None Present

### La Plata - 2 DELEGATES

None Present

### Montezuma - 1 DELEGATE

(D) Bloink, Steven W.

## DISTRICT V - 22 DELEGATES

### Arapahoe - 22 DELEGATES

(D) Barte, Roy M.

(D) Bartlett, Max D.

(D) Boulder, Joel C.

(D) Brenneman, Janice K.

(D) Burks, Jack S.

(D) Capek, Richard B.

(D) Foss, Frederick A.

(D) Heyman, Philip

(D) Jolly, Susan L.

(D) Knize, David M.

(D) Kruse, Robert L.

(D) Larkin, Thomas P.

(D) Levine, Mark A.

(A\*) Lewis, Frederick

(A) Palmquist, David L.

(D) Price, Jerry G.

(A) Ratner, Karen N.

(D) Reiner, Seth A.

(D) Stecher, Karl

(D) Steffen, Grant E.

## DISTRICT VI - 11 DELEGATES

### Aurora-Adams - 11 DELEGATES

(A) Ashkar, Louis

(D) Capin, Leslie R.

(D) Heaton, Angeline D.

(A) Heaton, Carl E.

(D) Gottula, Roderic D.

(D) Kraus, G. Thomas

(D) Rich, John D.

(D) Solomon, William A.

(D) Sundland, Barry R.

(D) Visconti, Paul B.

## DISTRICT VII - 12 DELEGATES

### Boulder - 12 DELEGATES

(D) Benson, Alan E.

(D) Berg, Kevin R.

(D) Bolles, Gene E.

(D) Farrington, John F.

(D) Kelley, Severance B.

(D) Mooney, Herbert S.

(D) Rubright, Mark W.

(D) Rupp, Gerald R.

(D) Stjernholm, Melvin R.

(A) Wherry, Harry L.

(D) Williams, William J.

## DISTRICT VIII - 20 DELEGATES

### Clear Creek Valley - 20 DELEGATES

(D) Brundige, Richard L.

(D) Cedars, Chester M.

(A) Chambers, Jodi A.



# Delegate Attendance – 1992 Annual Meeting

LEGEND (D) Elected Accredited Delegate (A) Elected Accredited Alternates \*(A) Substitute Accredited Alternates

(D) Daneshbod-Skibba, Ghodsi  
(D) Dorr, Eugene A.  
(D) Doyle, Herman E.  
(D) Golbert, Thomas M.  
(D) Henbest, Philip M.  
(D) Karlin, Joel M.  
(D) Laubach, Sherri J.  
(D) Mozia, Nelson I.  
(D) Netz, Howard E.  
(D) Oppenheim, Walter H.  
(D) Potts, William E.  
(D) Sadler, Dean L.  
(A\*) Tegtmeier, Ronald E.  
(D) Yakely, M. Robert  
(A\*) Yocum, Harold A.

## DISTRICT IX - 42 DELEGATES

### Denver - 42 DELEGATES

(D) Anneberg, A. Lee  
(D) Bailey, William C.  
(D) Bakemeier, Richard F.  
(A) Ballinger, Carter M.  
(A) Barmatz, Hirsh E.  
(A) Bogin, Robert M.  
(A) Bumgarner, Frank E.  
(D) Carson, Bonita S.  
(D) Cochrane, David R.  
(D) Cook, William R.  
(D) Foust, Glenn T.  
(A) Gibbs, Charles P.  
(D) Hedberg, John  
(A) Hutchison, David E.  
(A) Jacobson, Eugene D.  
(A) Kandel, George E.  
(D) Karel, James L.  
(D) Kelble, David L.  
(A) Kinzie, Jeannie J.  
(D) Major, Francis J.  
(D) Manart, Frank D.  
(D) McCartney, Robert D.  
(A) Moore, George E.  
(D) Nelson, Nancy E.  
(A) Owens, J. Cuthbert  
(D) Parsons, Donald W.  
(D) Reed, Barbara R.  
(D) Rhodes, Edward A.  
(D) Safford, H.R.  
(D) Sawyer, Robert B.  
(D) Schemmel, Janet E.  
(D) Sides, Leroy J.

(A) Stigler, Del  
(D) Walker, Louise C.  
(D) Wiedel, Jerome D.  
(D) Zbyski, Joseph R.

### University of Colorado Student Medical Society - 2 DELEGATES

(D) Batuello, Stephen G.  
(D) Laforo, Maura

## DISTRICT X - 19 DELEGATES

### El Paso - 19 DELEGATES

(D) Barry, Francis J.  
(A\*) Bengfort, John L.  
(D) Brusenhan, J. Richard  
(D) Crawford, Lewis A.  
(D) Emeis, William E.  
(D) Feldman, Laura L.  
(D) Goldmuntz, Barry M.  
(D) Lewis, Ted T.  
(A) Lloyd, William E.  
(D) Moore, Larry A.  
(D) Muth, John B.  
(D) Nielson, Peter G.  
(A) Pollard, Joseph S.  
(A) Rapp, Alan D.  
(D) Spaulding, Duane R.  
(A) Struck, Teresa H.

## DISTRICT XI - 10 DELEGATES

### Larimer - 10 DELEGATES

(A) Chase, Jerry A.  
(D) Danforth, James C.  
(A) Ezell, William W.  
(D) Giansiracusa, Richard F.  
(D) Hammond, Richard O.  
(D) Honea, Bertrand N.  
(D) Kaiser, Dale C.  
(A\*) Shachtman, William A.  
(A) Tagge, Gordon K.  
(D) Wera, Thomas J.

## DISTRICT XII - 6 DELEGATES

### Mesa - 6 DELEGATES

(D) Doran, John H.  
(D) Golter, Lee B.  
(D) Jones, Paul B.  
(A\*) Linnemeyer, Robert F.  
(D) Magraw, Bronwen J.  
(D) Sadler, Theodore R.

## DISTRICT XIII - 9 DELEGATES

### Pueblo - 9 DELEGATES

(A\*) Fowler, James B.  
(D) Gaide, Thomas K.

# Delegate Attendance – 1992 Annual Meeting

**LEGEND** (D) Elected Accredited Delegate (A) Elected Accredited Alternates (A\*) Substitute Accredited Alternates

(A\*) McCaffrey, Paul P.  
(D) Meeuwssen, James W.  
(D) Morgan, Alethia E.  
(A) Proctor, Carla R.  
(D) Ryals, Jarvis D.  
(D) Snyder, Charles E.  
(A) Wilz, William P.  
**DISTRICT XIV - 8 DELEGATES**  
**Weld - 8 DELEGATES**  
(A\*) Corona, Joe A.  
(D) Kemme, Richard J.  
(D) Sullivan, Patrick J.  
(A\*) Peterson, James H.  
(A\*) Quinn, Richert E.  
**Medical Staff Section - 1 DELEGATE**  
None Present  
**Colorado Academy of Family Physicians - 1 DELEGATE**  
None Present  
**Colorado Chapter - American College of Physicians - 1 DELEGATE**  
None Present  
**Colorado Society of Internal Medicine - 1 DELEGATE**  
(D) Bush, James F.  
**Rocky Mountain Gastroenterologic Society - 1 DELEGATE**  
None Present  
**Colorado Orthopaedic Society - 1 DELEGATE**  
None Present  
**Colorado Society of Anesthesiologists - 1 DELEGATE**  
(D) Hyde, Edwin G.  
**Colorado Chapter, American College of Surgeons - 1 DELEGATE**  
(D) Hildebrand, Jan S.  
**Colorado Chapter, American College of Emergency Physician - 1 DELEGATE**  
(A\*) Phelps, Dwight S.  
**Colorado Resident Physician Section - 1 DELEGATE**  
None Present  
**Colorado Gynecological & Obstetrical Society - 1 DELEGATE**  
(D) Thorne, Jack

**Colorado Young Physician Section - 1 DELEGATE**  
None Present  
**Colorado Ophthalmological Society - 1 DELEGATE**  
None Present  
**Colorado Psychiatric Society - 1 DELEGATE**  
None Present  
**Women In Medicine Section - 1 DELEGATE**  
None Present  
**Colorado Child & Adolescent Psychiatric Society - 1 DELEGATE**  
None Present  
**Colorado Neurosurgical Society - 1 DELEGATE**  
None Present  
**Colorado Otolaryngology & Maxillofacial Society - 1 DELEGATE**  
None Present  
**Colorado Dermatological Society - 1 DELEGATE**  
None Present  
**Rocky Mountain Academy of Occupational Medicine - 1 DELEGATE**  
None Present  
**Colorado Society of Clinical Pathologists - 1 DELEGATE**  
(D) Stienmier, Richard H.  
**Colorado Radiological Society - 1 DELEGATE**  
None Present  
**Colorado Society of Dermatological Surgery - 1 DELEGATE**  
None Present  
**Colorado Allergy Society - 1 DELEGATE**  
(A\*) Vedanthan, P.K.





September 20, 1992

Dear Editor:

The recent action of the president and board of directors with regard to Governor Romer's initiative, "Children First," was the topic of debate at the recent annual meeting of the Colorado Medical Society at Copper Mountain. As a result of this debate, a resolution was introduced, amended and adopted to direct the Legislative Council to develop guidelines for the president and board, restricting their activity to "medically related political issues." The implication of this action was that the response of the president and the board to Governor Romer's request was inappropriate as it lay outside the scope of "medically related political issues." How do we now define what constitutes "medically related political issues"?

The delegates expressing their displeasure with the board action apparently define medically related issues as those related only to the daily practice of medicine. They have forgotten that they practice medicine only because others had the foresight and concern demonstrated by Governor Romer to provide an education system that trained not only future doctors, but nurses, technicians and other personnel that make the practice of medicine possible.

Let us hope that as the heat of debate dies and we consider these issues carefully, we recognize that we practice in a community where medically related political issues

include many facets. Let us also hope that the Legislative Council does not define prerogatives of the president and the board so narrowly that these issues cannot be addressed.

*Donald G. Eckhoff, MD  
Member, CMS Board of Directors  
Member, DMS Board of Directors*



*Governor Roy Romer as he spoke to the assembled delegates at Copper Mountain in September, explaining "Children First," an educational finance initiative he is advocating to solve a budget crisis.*

August 26, 1992

Sandra L. Maloney, Exec. Director  
Colorado Medical Society

Sandi — My "yardstick" of how good *Colorado Medicine* is each month is measured by how many articles I tear out to share with committees, etc. There are only a few pages left in the August issue! I've also been in two meetings where doctors referred to articles they'd read.

Thought you should know; somebody out there does appreciate all the work.

*Carol Walker  
El Paso County Medical Society*



Mary Jean Berg, MD (left) presents the National Science Ambassador award to Ordway science teacher Sheila Thruston

# Ambassadors of Science

Colorado Medical Society member and chair of the CMS Medical Service Council Mary J. Berg M.D. has presented the National Ambassador Science Project award for excellence as a teacher in the area of science to Sheila Thruston. Sheila is an elementary science teacher in Ordway Colorado. The National Ambassador award is sponsored by the Colorado Medical Society in conjunction with the American Medical Association. It is designed to recognize teachers who are truly committed to broadening their students' horizons and stimulating an active interest in the area of scientific study. Sheila received her degree in teaching from the University of Northern Colorado in Greeley. Sheila has been a teacher for 19 years. She is originally from Hugo, Colorado where she was instrumental in starting the local science fair which has been active for the past 15 years. When asked what gives her the most satisfaction as a teacher Sheila stated, "I take a hands on approach to teaching. It's gratifying to see the excitement and enthusiasm expressed by the kids when they see a project or experiment unfold before their

eyes. Almost all the children look forward to science class."

Exposing young students to science and instilling in them a hunger for knowledge is the key to our future. The Colorado Medical Society congratulates Sheila Thruston on this award and commends her for excellence in teaching.

*Photo & story by Gil Maestas, II for Colorado Medicine*



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**Ben Galloway, MD**  
Chairman  
CMS Participation '92



**Patti Brown**  
CMS Auxiliary Legislative Affairs Chairman 1991-1992  
Co-Chairman CMSA Participation '92



Thank you for your encouraging response to our listing of the candidates in last month's issue. There are two additional candidates who were not known at press time. **Vern Tharpe** will run as an independent candidate in the 2nd Congressional District against David Skaggs and Bryan Day and **Peggy Lamm (D)** from Boulder will run for House District 13 against Republican Drew Clark.

In addition, we have taken the suggestion to print the phone numbers of the county elections offices below. Contact them if you have any questions about what district you are in, or where to vote.

Your vote may be more important this year than ever before. Don't take the chance and allow your office hours or an emergency keep you from the polls - Vote by absentee ballot! You may request an absentee ballot by contacting your local election commissioner or County Clerk. In certain special locations, you may cast an absentee ballot in person on October 19. Call the County elections office to find out where.

Adams	303-659-7850
Alamosa	719-589-6681
Arapahoe	303-795-4511
Archuleta	303-264-5633
Baca	719-523-4372
Bent	719-456-2009

Boulder	303-441-3516
Chaffee	719-539-4004
Cheyenne	719-767-5685
Clear Creek	303-534-5777
Conejos	719-376-5422
Costilla	719-672-3301
Crowley	719-267-4643
Custer	719-783-2441
Delta	303-874-9792
Denver	303-640-2351
Dolores	303-677-2381
Douglas	303-660-7444
Eagle	303-328-8710
Elbert	303-621-2080
El Paso	719-520-6225
Fremont	719-275-7521
Garfield	303-945-2377
Gilpin	303-582-5321
Grand	303-725-3347
Gunnison	303-641-1516
Hinsdale	303-944-2228
Huerfano	719-738-2380
Jackson	303-723-4334
Jefferson	303-271-8806
Kiowa	719-438-5421
Kit Carson	719-346-8638
Lake	719-486-1410
La Plata	303-259-4000
Larimer	303-498-7820
Las Animas	719-846-3314
Lincoln	719-743-2444
Logan	303-522-1544
Mesa	303-244-1662
Mineral	719-658-2440
Moffat	303-824-5484
Montezuma	303-565-3728
Montrose	303-249-3362
Morgan	303-867-5616
Otero	719-384-8701
Ouray	303-325-4961
Park	719-836-2771
Phillips	303-854-3131
Pitkin	303-920-5180
Prowers	719-336-4337
Pueblo	719-546-6000

Rio Blanco	303-878-5068
Rio Grande	719-657-3334
Routt	303-879-1710
Saguache	719-655-2512
San Juan	303-387-5671
San Miguel	303-728-3954
Sedgwick	303-474-3346
Summit	303-453-2561
Teller	719-689-2951
Washington	303-345-6565
Weld	303-356-4000
Yuma	303-332-5809

A total of 13 referendums and initiatives will appear on the ballot. The CMS has copies of the ballot analyses which are prepared each election year by the Colorado Legislative Council. We recommend that you obtain a copy of the ballot analysis by contacting the CMS Government Relations Department (1-800-654-5653 or 779-5455), then carefully review the pros and cons of each amendment prior to casting your vote.

The Colorado Medical Political Action Committee (COMPAC) has completed its review of congressional and state legislative candidates based on four criteria: 1) past voting records of incumbents; 2) personal interviews; 3) recommendations of COMPAC members; and 4) statistical analysis of the district. The results been forwarded to all component society presidents and medical executives. If you need information on candidates, we urge you to contact your CMS Government Relations staff. They will be happy to share their knowledge of most all Colorado candidates with you. (telephone number listed above)

**VOTE on November 3!!**

## on The Campaign Trail:

John Ellett MD, -



As a University of Colorado Regent candidate and CMS member, I have been campaigning in the twenty three Eastern Colorado counties of the Fourth Congressional District. There is a definite health benefit to walking in parades, attending county fairs, shaking hundreds of hands and explaining over and over what Regents of the University of Colorado are supposed to do.

I continue to hear support for further expansion and provision of primary care providers from the University's Medical School. Also the need for greater access to the University's programs at a more affordable price is frequently mentioned.

It seems apparent that the University Health Center can provide a better service to the state and its people by attempting to put physicians-in-training and other health professionals into supervised situations in the rural and underserved areas of the state. These professionals would have the backup and administrative help of the University of Colorado Health Sciences Center.

Why am I running for Regent? As a Colorado native with over three decades of volunteer faculty participation and three degrees from CU, I am well aware of the importance of having a practicing physician on the board. I could not let the retirement of Dr. Roy Shore of Greeley pass without meeting that need.

A great deal of the University's activities are centered around the Health Sciences Center. With my medical and business background, I hope to give input on budgeting and policy decisions that are unique to the medical profession. Besides, Dr. Pat Sullivan, Colorado Representative from Greeley, thinks it's a good idea, and who am I to argue with him?

I am grateful for the endorsement of the Colorado Medical Society, but nevertheless, I cannot improve your football seats. I do solicit the continuing support of the medical community and appreciate the aid I have received from the CMS.



# Thanks Go To Physicians Who Served As Special Judges at Successful '92 Colorado State Science Fair



*Drs. James Regan and Thomas Flower examine some of the exhibits at the Colorado State Science Fair in Fort Collins.*

Nearly 400 middle- and high-school students participated in the April 9-11 Fair. Of these, more than 25 entries were judged under the medical science criteria. The winners, Warren Gasper of Fort Collins and Diann E. Miyake of Englewood.

Three special judges for Colorado Medical Society were **Drs. James Regan of Denver, Thomas Flower of Greeley and Russell Bobo of Fort Collins.**

Drs. Regan and Flower are CMS members. Dr. Regan is the Chairman of the Young Physician Section. Dr. Flower has been active since its inception in the CMS Correctional (Jail) Health Care Program. Dr. Bobo is an Anesthesiologist.

Winners of the Junior and Senior Divisions in the medical sciences competition will display their exhibits at the CMS Annual Meeting in September at Copper Mountain. Each winner will receive a \$100 US Savings Bond.

Drs. Regan, Flower and Bobo interviewed each of the contestants. Each contestant is interviewed about the experiment exhibit as the judges base their decisions on both the

personal knowledge of the entrant as well as the physical exhibit.

One of the Colorado State Science Fair pioneers, **Dr. H. Calvin Fisher (Ret) of Colorado Springs** was on hand as well. The special judging was an excellent opportunity to bring these physicians together, all of whom have special interests in promoting the natural sciences in

our schools at an early age. Dr. Regan, in recent years, has been promoting the CMS "Natural Science Ambassador" program, finding physicians to become classroom ambassadors for natural science studies in grade school and up. Dr. Fisher continues to urge CMS members to play a major role in the Science Fair which, he says, forms an excellent relationship with this important sector of the patient/public.



*Dr. Russell Bobo, here balancing the paperwork with inspection of the exhibits, discovers many factors to judging a science project.*



*Volunteer judge Thomas Flower, DO, confers with long time science fair supporter H. Calvin Fisher, MD. Dr. Fisher's advocacy of this effort at science education was cited as a major reason he was awarded the 1992 A. H. Robins Award for Community Service by a physician.*

# Parent-Professional Partnership

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*"All physicians caring for children in **Fremont County** have agreed to participate."*

## **A Parent-Professional Partnership is Underway in Fremont County**

In Fremont County the Medical Society, Project ECHO and the Department of Pediatrics of the University of Colorado School of Medicine are co-sponsoring a program titled "Partners in Preventive Health Care". The partners are parents, health providers and a community coordinator. The coordinator, Martha Lankford, works under the general direction of local physicians, tracks the children enrolled in the program and provides computerized feedback to physicians to ensure that the children receive all appropriate services and that suspect findings are followed up.

A major emphasis of the program is to assure that children reach school age physically and emotionally healthy and ready to learn, a goal emphasized by U. S. Surgeon General Antonia C. Novello. The program includes specific measures such as immunizations, screening to identify disease and disability early in life, and parent education to prevent injury and stimulate development.

The Partners project involves the Denver Child Health *Passport*, a parent-held health record covering the first six years of life. Developed by William K. Frankenburg, M.D., the colorful 6 X 9 inch spiral-bound book provides a comprehensive record of delivery and nursery data, family history, well child visits, immunizations, and growth and development.

Women delivering at St. Thomas More Hospital in Canon City are invited to participate in the program; those who agree receive a free *Passport*. Prior to each well child visit, parents fill out their infant's history and indicate any concerns; the physician records findings from the examination and provides parents with health education prompted by the *Passport*.

Self-copying paper generates three copies of this information at each visit. The original stays in the *Passport* which is retained by the parents. The second copy is removed for the physician's records. The third copy goes to the coordinator who tracks children by computer to ensure that they receive all check-ups, immunizations, and other important services such as developmental screening. If non-compliance is found or if a problem is suspected, the coordinator notifies the child's physician so that appropriate steps can be taken.

All physicians caring for children in Fremont County have agreed to participate. The Fremont County Medical Society has donated \$900 to purchase *Passports* for parents, and additional support has come from Copic Insurance Company, The Department of Education, St. Thomas More Hospital and County Health.

The initial trial of the *Passport* in Fremont County in 1990 involved 200 newborns; 96% of the parents agreed to participate. Suggestions from parents and health providers were used to revise the *Passport*. A second trial is currently underway to study whether compliance with



# in Fremont County

ED: Gary Mohr, M.D., is a board certified family physician in private practice in Canon City, and is president of the Fremont County Medical Society.

immunizations is improved, and whether developmental disabilities are identified at an earlier age. Initial response to this second field test from both parents and professionals has been better than hoped. It is anticipated that the *Passport* will soon be available for statewide and national use.

Dr. Mohr said, in discussing the project with **Colorado Medicine**, said "I am proud that Fremont County was chosen for the trial, which has been extremely successful. All doctors in the county who care for children participate, remarkable in itself for such an intransigent group. Not only do we use and promote *Passport*, we donated money to buy *Passport* for the trial." Dr. Mohr also told us that Dr. Wm. Frankenburg reported on the success of the program at an international pediatric meeting in Portugal on August 25th.

CMS was pleased to have sponsored an August reception for Rosalynn Carter, Betty Bumpers (wife of Ark. Sen. Dale Bumpers) and Bea Romer to thank participants in Colorado's effort to update legislation requiring child immunization (see *Changes to Immunization Requirements, Colorado Medicine, Vol 89, No. 8: 264-265*). Mrs. Carter, Bumpers and Romer have been active over the past decade in their efforts nationwide to standardize state and federal laws pertaining to early immunization. Members of a CMS Task Force on Immunization played an active and major role in passage of the new legislation.

## Former First Lady in Colorado about Childhood Immunization



Dr. Gary A. Mohr is shown discussing the Denver Child Health Passport with former First Lady Rosalynn Carter during her recent visit to Colorado to promote routine immunizations for all children. On the left is Sarah Smith with her son, Jordon, who along with older brother Ian, is in the *Passport* program.

(Photo courtesy of the Canon City Daily Record.)



Edie K. Register, Director

# Evaluation and Management Codes

Grant Steffen, MD

Medical Director, Medicare Part B  
Blue Cross/Blue Shield of Colorado, Inc.

*"To help me with those guidelines, please share your thoughts about how you think HCFA should define this exam."*

In a previous issue, I quoted HCFA's definition of a comprehensive *history* and then gave you my analysis of the four levels of a *physical exam*, acknowledging that I did not know what a "complete single system specialty exam" was. Since I wrote that article, HCFA has directed all Carrier Medical Directors to make no new policy regarding the single specialty exam. The analysis of and recommendations for this exam will be the subject of our semi-annual meeting. From this meeting should come some workable guidelines on how we should understand the contents of a single system specialty exam.

To help me with those guidelines, please share your thoughts about how you think HCFA should define this exam. Remember, since this specialty exam is given the same level of intensity as the complete multi-system exam, the specialty exam should entail about the same amount of work as the multi-system exam.

The HCFA document that I quoted also instructed us on other E/M code issues, an important one being the admission H&P. Note that the initial hospital care codes have three levels, and all three require both a comprehensive history and a comprehensive exam. The difference in the three levels depends entirely on the level of the medical decision

making. So, the question is: What do you bill if you didn't do a comprehensive exam? There are, of course, many situations when that level of history or exam is not needed.

The answer is, bill 99221, the lowest of the three initial visit codes. Also, if you did an office comprehensive evaluation some days prior to admission, you may bill that visit at whatever level its contents indicate in addition to the 99221 for the less than comprehensive re-evaluation on the day of admission. These comments refer to a medical admission.

Things get a bit more complex when it is an elective surgical admission. A basic rule here, a rule that comes from the CPT description, is that the initial hospital care codes can be used only by the admitting physician. So, if the surgeon is the admitting physician, the admitting H&P is not billed at all, since it is part of the global surgical fee. The exception is, if the decision to operate is made at the time of that admitting evaluation, it can be billed separately.

If the surgeon asks the patient's primary care physician to do the admission H&P for "surgical clearance," that physician cannot bill using an initial hospital code. Remember, those three initial hospital visit codes are available only to the admitting physician. So the primary care physician bills for



the admission H&P using a subsequent visit code, even though the service was performed the day of admission.

If the surgeon asks a physician who is not the patient's primary care physician to do the admission H&P, and that physician has not seen the patient for three years (a "new" patient), that physician may use a consultation code to bill for the admission H&P. The primary care physician should not use the consultant code since the initial hospital evaluation can be considered a part of ongoing care.

If the surgeon is a limited license practitioner, (podiatrist, dentist) and can admit to the hospital, but needs to have an MD/DO do the H&P, again, that physician should bill a subsequent hospital visit if the physician is the patient's primary care physician, or bill a consultation code if not. Again, the MD/DO cannot use the initial hospital visit codes. Those are available only to the admitting "physician."

However, if hospital regulations do not permit the podiatrist or dentist to admit, then the MD/DO will be the admitting physician and use the initial visit code.

To summarize, the *primary care* physician should usually not use consulting codes, and only the *admitting* physician can use the initial hospital care codes.

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# Colorado Gynecological and Obstetrical Society

by Betsy Fox

*For information about membership meetings and to RSVP, call 693-6127. For information about other Society Community Programs, call Betsy Fox at 355-8845.*

## September Membership Meeting

The September membership meeting was held September 14, with Marilyn Van Derbur Adler as the Keynote Speaker. Ms. Adler, Outstanding Woman Speaker of America, spoke on "How the Medical Community Supported and Violated Me, A Story of Hope." This was the kick-off meeting for the Colorado GynOb Society's Fall and Winter activities.

## Teen Pregnancy Prevention

The Teen Pregnancy Prevention Program has received ten poster concepts from the Denver Advertising Federation. The posters were reproduced and made available in September. Each one says "One Moment Can Change Your Life" with a different visual presentation. For information and availability, call 355-8845.

## Positive Publicity

In July, the Rocky Mountain News printed a letter to the editor from President Jamie McGregor, which listed some of the many contributions the Society has made in recent years to increasing access to health care for Colorado women, including receipt of the prestigious Wyeth Award as outstanding chapter in the

US. Also in July, Westword selected the Colorado GynOb Society as "Best OB/GYNs" for the community activism, including increasing Medicaid physician coverage, collaboration with prenatal care advocacy groups, and receipt of the Wyeth Award. A letter was received in July from Representative Patricia Schroeder, congratulating the Society on receipt of Westword's accolade.

## Health Care Access Symposium

The Third Annual Health Care Access Symposium will be held on October 30, 1992. This "think tank" meeting is entitled "Creating a Model: Health Care Coverage for Women, Children, and Families." The Symposium will be held at the Denver Hilton South. Registration begins at 8:00 am and the Session will begin at 8:45 with a Keynote presentation by Representative Schroeder. The half day session will include lunch and adjourn at about 1:30 pm. Individuals representing a broad spectrum of the community will be invited to discuss the special problems women, children, and families face in obtaining quality health care coverage, and will then be asked to develop concrete proposals that can be translated into a model state Health Care Coverage package. To RSVP, call 355-8845.



# Highlights: Board of Director's Meeting

## September 10, 1992

**Medical Student Component:** Maura Lofaro, Student Representative, reported that she spoke at the Freshman Student orientation and several students indicated an interest in joining the Component. Ms. Lofaro also stated that the Women in Medicine Section is planning a mentorship program.

**Executive Committee:** The Board ratified the following actions of the Executive Committee, 1) to support the Children First Tax Initiative by funding the mailing of letters to CMS members, contributing a \$1000 to the campaign and to invite the Governor to speak at the Annual Meeting, 2) to withdraw the monetary support and in-kind services to the Colorado Health Careers Council, and 3) to submit the resolution on Health Care Reform to the House of Delegates.

**Finance Committee:** The Board ratified the action of the Finance Committee in denying a request for additional monies from the Colorado Domestic Violence Coalition but to continue to provide in-kind services as appropriate.

**Board of Directors:** Dr. Butler presented the outgoing Board members, Drs. Sbarbaro, Hanson and Klein with plaques in recognition of their service as Board members. Dr. Doig was not present but will be receiving a similar plaque for his service as well.

# An expensive charting system is one that *doesn't* work.



**Subjective:** "The Plaintiff's husband had his first embolism  
21 months ago."

**Objective:** "Doctor, please show the COURT that  
record in your chart."

**Assessment:** "Oh ... #@\$#@\* .....  
..... I can't find it!"

**Plans:** ..... Call BIBBERO!!!

Contact Sue Lewis or Tom Rothgeb at (303) 969-9997 or (800) 358-8240 Ext. #83

# Better Communication

It comes in many forms

Michael P. Thompson  
Assistant Managing Editor-

*"I didn't realize that patients were having difficulty understanding me."*

"Could you repeat that, Doctor?"

How many times have you heard this question? Perhaps not as often as you should have. Ravi Paul, MD, a native of India and director of Adolescent Medicine at St. Luke's Hospital in Cleveland, says, "I didn't realize that patients were having difficulty understanding me." He needed help with his foreign accent, but didn't know it.

It's not a matter of changing your cultural identity or demeaning your intelligence and ability. It's a matter of communicating more clearly with patients and others. Some foreign born physicians have studied English for years, starting in elementary school. And they have achieved an excellent mastery of the grammar and syntax. But their examples on pronunciation were from other natives of their home countries.

According to Colorado Communication Consultants, "A foreign accent is the mixing of sounds and inflection patterns from one's native language with those of English." The severity of the accent is determined by how much it distracts a native listener from the content of the message.

Dr. Paul, for example, before enrolling in a program on accent modification, said, "I would say I didn't have a problem." After his wife pointed out some words he had difficulty with, he tried to correct his own accent, with frustrating results. Then he took a course in accent modification. "It took me two hours to make that 'th' sound," he confesses, identifying one of the most

difficult sounds for non-English speakers to make. Susan Saltzman, who taught the course, says "As far as I'm aware, this sound doesn't exist in any other language, anywhere."

In fact, one writer to Dear Abby told the story of an emergency room physician who apparently asked if she was still "breathing." After some consternation, it was realized that it was "bleeding" he was concerned about, and that "th" sound was the culprit.

Ms. Saltzman says that the "r" sound is actually the most difficult to master, as many languages have it, but each does it differently, from the Spanish trilling "r" to the German one that comes from the back of the throat. Substituting "v" for "w" and "z" for "s" are other problems (Ve vent to de store to get zome zizzors.)

One of the big difficulties when a physician is pronouncing words in a manner consistent with another language is that patients are often intimidated by them and reluctant to ask them to repeat things. Given the chance, many will ask the nurse to explain later, but not all have that chance. You know what problems this could cause with adherence to medical instructions.

In fact, Shellie Bader, a West Los Angeles Speech Therapist, says "A person can be very competent in his field and assumes that others understand him. He may have no idea that he isn't communicating clearly." And because of the proliferation of physicians in many areas, the patient may not even bother to tell the physician that he or she is not being



understood. The patient may merely find another physician. This should make a great deal of difference to the estimated 18% of physicians who were born outside this country.

One of the difficulties is the old adage, "When in doubt, mumble." Many foreign born practice this, making communication even more difficult. A good, scientific accent modification course can help.

"The goal is not to turn people into television announcers," says Terrell J Evans, MA, a speech and language pathologist in Denver, "but to modify the accent to improve clarity." Ms. Evans and her associate, Poorna Crampton, MA, a native of India who speaks with no discernible accent, teach several courses on accent modification, apparently with marvelous success. Tuoc Huu Do, MD, of Rochester MN took this same course, and said, "I still can't believe how much my speech has changed."

The courses do not remove or eliminate an accent. One writer said, "You learn to speak more clearly, yet still retain the charming hint of foreign shores in your speech." A big obstacle in learning any foreign language (and English is one of the most difficult), according to Ms. Evans, is the fact that our speech patterns are fixed by adolescence, "When learning languages at an older age, you hear through your mind's ear of your native language." Thus, you may not even be able to hear the sounds you are pronouncing incorrectly, at least not without help.

Add to this the fact that Americans are not well acquainted with

foreign languages, at least compared to other countries. We don't have the regular intercourse with people who speak a language other than our own which would familiarize us with different pronunciation patterns.

Good communication has been proven to increase patient adherence to a treatment regimen and lessen the chance of malpractice litigation. Accent modification is an excellent way to enhance communication. For more information, contact Colorado Communication Consultants at (303) 758-8090.

*Terrie Evans and Poorna Crampton demonstrate their technique with CMS staff member Sandra Finney.*



Photo by Gil Maestas, II



### Lupus is Hard to Detect

Veronica Dolan  
*Lupus Foundation of Colorado*

A Castle Rock woman whose life was irrevocably altered when she was stricken with lupus understands the importance of early detection of the incurable auto-immune disease. Vicki Shaw's diagnosis was late in coming. Now 33, she believes the serious afflictions she contracted when she was thirteen was not pleurisy, as diagnosed by her physician, but lupus.

"At that time I had to curtail school sports because of inflammation of my knees," she says, "and I had periodic problems with swelling and joint pains until I was eighteen. Doctors later thought I had multiple sclerosis, then a brain tumor. They also suggested I might have psychological problems and sent me to a psychiatrist, who definitely determined the problem was physical.

"I was finally diagnosed with lupus when I was 20. Doctors told me I had a mild case and symptoms would probably go away and I would not have the disease anymore."

Many physicians have trouble diagnosing systemic lupus erythematosus (called SLE or lupus for short) because symptoms of the chronic inflammatory disease of the connective tissues vary greatly, mimic those of other diseases and wax and wane as patients go into remission.

The average patient may suffer for three to ten years before getting a proper diagnosis, which is why the Lupus Foundation of Colorado (LFC)

works to educate the medical community about signs and symptoms of the disease and holds an annual symposium for physicians, patients and their families, set this year for Saturday, October 17 from 11 am to 4 pm at Craig Hospital, 3425 S Clarkson St in Englewood.

Speakers and topics include Kenneth Glassman, MD — "Overview of Lupus & Medications Used for Treatment," Michael Schiff, MD — "Effects of Lupus on the Brain and Nervous System," Stuart Kassan, MD — "The Many Faces of Sjorgren's Syndrome," and J. Woodruff Emlen, MD — "Understanding Laboratory Tests."

Doctors Glassman and Schiff serve on the LFC medical advisory board.

Because of the lupus, Vicki Shaw had several strokes and she continues to experience periods of confusion and memory loss. She is now divorced and on full disability, but remains optimistic.

"Lupus hasn't stopped me," she says, "I'm very active. I drive, I walk, manage my home, do volunteer work for my church, the children's schools, and for the Lupus Foundation."

Vicki says her big problems now with the disease are fatigue and joint pains, which make her more frustrated than depressed. She says having good friends and a good LFC support system have helped her survive.

The Lupus Foundation of Colorado is a not-for-profit agency dedicated to improving the quality of life of people affected by lupus and to promote efforts for the education,

diagnosis, treatment, prevention and cure of the disease, for which there is no known cause. It is estimated that some 5,000 people in Colorado have lupus, which strikes women nine times more frequently than men, especially women of child bearing age. The disease is three times more prevalent among African-American women than white women and also affects Hispanics and Orientals.

Further information about the symposium and the Lupus Foundation of Colorado is available by calling (303) 922-5259.

The Lupus Foundation of Colorado urges people to seek medical help if they experience any of the following symptoms:

- Joint pain and/or swelling for more than three months
- Mouth sores that persist for more than two weeks
- Prominent rash on the cheeks for more than one month
- Skin rash other than sunburn after exposure to the sun
- fingers that become pale, numb, or uncomfortable in the cold
- Pain when taking deep breaths that lasts for more than a few days (pleurisy)
- Rapid and significant hair loss
- Episodes of seizures or convulsions
- Extreme, persistent fatigue, along with two of the above symptoms





## Rainer Honored at Alma Mater

**W. Gerald Rainer, MD**, Past-President of the Colorado Medical Society, was honored with the 1992 **Distinguished Alumnus Award** by the University of Tennessee Medicine Alumni Association for "distinction in active medical practice" at a recent meeting in Memphis.



The Association said Dr. Rainer is "considered an expert in the field of thoracic and cardiovascular surgery." He

has been a visiting professor at medical centers in the United States and Canada, and has been guest lecturer in the Soviet Union, England, the Philippines, Romania and Czechoslovakia. In addition to his term as President of the Colorado Medical Society, Dr. Rainer has been President of the American College of Chest Physicians, the Association for Advancement of Medical Instrumentation, the Colorado Heart Association and the Society of Thoracic Surgeons. He has held other offices in numerous organizations.

## Animals in Research

The American Medical Association (AMA) is pleased to have Colorado Medical Society and the University of Colorado Health Sciences Center as co-sponsors of a one-day workshop (10:30 a.m. - 5:00 p.m.) on Monday, November 16, 1992. This session is designed to build grass roots support for the use of animals in research via physicians, research-

ers and students — individuals viewed by Americans as trusted and balanced sources of medical and scientific information.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education (CME) for physicians.

The AMA designates this CME activity for 6 credit hours of Category 1 credit of the Physician's Recognition Award of the AMA.

Registration is **free** to all medical and graduate students and residents;

\$25 to members of the AMA, Colorado Medical Society and University of Colorado Health Sciences Center and \$35 to non-members. The fee includes continental breakfast, a coffee break, lunch and a comprehensive resource kit that includes background information, speeches with corresponding slides, video, sample letters, etc.

To pre-register, please call the AMA on or before November 10, 1992, between 9 a.m. - 4:45 p.m. Central Standard Time at 312/464-4574.

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### ALAC Honors Distinguished Physicians

The American Lung Association of Colorado and the Colorado Trudeau Society will honor two physicians at a reception dinner October 21 in Lakewood. Roger Mitchell, MD and Jack Durrance, MD will be honored for "their tremendous contributions in the area of respiratory health." Dr. Mitchell is a member of the Colorado Medical Society.

Call 388-4327 for more details.

### Community Prevention of Influenza in Colorado

*Steven R. Mostow, Rose Medical Center*

Prior to 1983, Colorado averaged approximately 16,000 reported cases and 900 reported deaths from influenza. Then a public awareness campaign was begun. During the past eight seasons, the number of persons immunized in public clinics has increased from 32,000 to 140,000, while the number of cases of reported influenza has declined from an average of 16,000 to 7,000. The number of influenza related deaths reported by the Colorado State Health Department has also dropped.

During the past season (1991-1992), there was an especially severe epidemic of A/Beijing influenza in the United States. Colorado was one of only three states which did not experience excess mortality. Medicare has recently announced that the state of Colorado is the most highly immunized state in the U.S.A. Thus, the awareness program has encouraged high risk persons to ask for

vaccinations in their physicians' offices.

Colorado experiences epidemic influenza and related flu and pneumonia mortality on an annual basis. Influenza vaccine is an effective way to prevent epidemic disease and mortality, yet few high-risk patients were being immunized. To increase the awareness of influenza's impact and those at risk for complications, this community-wide awareness program was developed by creating a committee known as the Influenza Alert Committee of the American Lung Association of Colorado. The committee is comprised of physicians, public health nurses, the Visiting Nurses Association, a major health maintenance organization, the American Lung Association of Colorado, grocery stores, pharmacies, and representatives from print and electronic media, as well as representatives of the state and county health departments. Through this committee's activities, influenza vaccine has been provided at low cost in non-traditional sites, such as grocery stores, pharmacies, public health clinics and work places.

The committee provides information to the public about influenza vaccine, the disease and its prevention, by advertising on grocery bags, milk cartons, and even food trays for home-bound citizens. Information is also posted in pharmacies and available in prescription bags. Press conferences are held, frequent television and radio appearances are made, a letter is sent to primary care physicians and nursing home directors, and public service announcements are provided during

prime-time television. A telephone "hot-line" was installed, providing taped information regarding availability and location of vaccine delivery programs, and the progress of the epidemic nationally. Sources of funding include donations from a variety of local and national firms.

This project has demonstrated that a community-wide approach to influenza can increase awareness of the disease, its complications, and its prevention. In addition, the safety and efficacy of providing vaccines in readily accessible locations for the public has proven extremely successful in reducing the impact of influenza A by increasing the utilization of vaccine in high risk groups at both public clinics and physician offices. Please ask your office staff to remind patients that October and November are the perfect months to receive their annual influenza vaccinations in your office.

### Communicate before you medicate

October is Talk About Prescriptions Month. Call the National Council in Patient Information and Education at (202) 347-6711 to find out more.

### Smoking Ban Shaky

Americans for Nonsmokers' Rights is rallying support to retain the smoke-free atmosphere in Denver's Airport. They are urging citizens (and physicians are well respected citizens) to write Mayor Wellington Webb to counteract pressure by tobacco companies. Call GASP of Colorado at 925-8990 to find out how you can help.



# Cramped and tongue-tied writers

by Thomas H. Coleman, M.D.

**Must we be eternally doomed** to the meaningless cliches now in universal fashion with bureaucrats and some writers of the news? Columnists and editors want to scare me by saying my proposal would "throw out the baby with the bath water." Maybe that baby *should* be thrown out. Recycle the water.

Let's throw out the bath water full of "nature, cases and basis." We're all for nature, but if poisons can kill you, why not say they're lethal poisons, not "poisons of a lethal nature"? Death from poison ain't natural. Can't we just say "in Lebanon" or "for Ross Perot" instead of "In the case of Lebanon" or "In the case of Ross Perot"? Does everything have to be encased? In discussing sales taxes, should we have one "in the case of beer"? After a bombing were there really "eighty-five cases of people dead on arrival"?

Must there be a "basis" for everything? We could do something *daily* instead of "on a daily basis." Why not sell tickets to first come, first served, without doing it on that "basis"?

Would headline writers please decide whether they want a "level playing field" for George Bush and the Congress, or a "slippery slope" because they are "comparing apples with oranges"?

**In speaking of doctors** and illness, do we have to clutter the text with "see your doctor for his or her advice and do what he or she says?" If we must be frightened of gender gaffes, let's not slash the sexes apart with "he/she" and "him/her." A woman writer could use her pronouns, a man could use his. If it

would make they/them feel better. While we are cutting slashes we can eliminate "and/or" (and/or the writers who use it).

An art critic said a sculpture had no importance "in and of itself." Just say it was not important, without the garbage. I don't need to hear that a restaurant is "arguably the best in town." Best is good enough without an argument.

**Will we ever be free** of "-ize" and "-wise"? A specialist consultant actually wrote "this patient does not have any problem ear nose and throatwise."

Can we reduce anything or make something smaller without downsizing it, or do it first instead of prioritizing the project? At some point in time, that is? And then there's this other "scenario." People are not either joyful or hurting, they are *experiencing* joy or pain. It is also "impacting" them. Painful indeed.

Last and least are the deadly philosophers and sages., stunning us with "The more things change the more they are the same" usually written (but rarely spoken) in French, or that tiresome wisdom "What goes around comes around." And please, let's never again say it's never over "until the fat lady sings."

My exclusionary rules will cramp and tongue-tie a lot of writers and speakers. Maybe that's the trouble. There are not enough parameters in the time frame. Perhaps what we need is, y'know, a "sea change," whatever that is, I mean, whatever. But will it *resonate*? Ciao man!

*"... why not say they're lethal poisons, not "poisons of a lethal nature'"*

**Ed. Note:** The editor has nothing to add /subtract.



## RUMINATIONS

(def: to chew again what has been chewed slightly and swallowed; to **REFLECT**)

**William S. Pierson**

Managing Editor

"... their performance was "extremely poor," according to the authors of the study published in the *Journal of the Royal College of Physicians*."

There are those who'd argue that the British health care system is the way all national, socialized health care should go... including the United States. The reprint (below) from the *London Times* gives pause for thought. Granted, it's worth a laugh, but might there be some deeper or underlying meaning?

No one has checked on the "kiss of life" in Canada. This could be a worthy subject for future research, since recently we've been talking more about adapting the Canadian-style nationalized health care system.

*Reprint from the London Times of July 10, 1992*

### In case of emergency, don't call for a doctor

By JEREMY LAURENCE

HEALTH SERVICES CORRESPONDENT

*LONDON TIMES*

If you are going to collapse, it may be thought the best place to do so would be in hospital. But a new study of consultants' skills in giving the kiss of life suggests most people would stand a better chance if found comatose by a passer-by in the street.

Of 24 consultants at Bedford General hospital who volunteered to demonstrate how they would attempt to revive a collapsed patient, 42 percent performed so poorly they scored zero marks. None was judged "adequate" in giving mouth-to-mouth resuscitation and compressing the chest, when measured against the standard laid down by the Resuscitation Council of the UK.

The consultants, with an average 20 years medical experience, were asked to carry out basic life support, on a manikin laid on the floor, with the help of a non-medical "passer-by." They were scored on a range of factors including the rate of compressions of the chest and whether the breaths given ventilated it properly. But in every case their performance was "extremely poor," according to the authors of the study published in the *Journal of the Royal College of Physicians*.

"What this shows is that if a consultant came across a collapsed person in the street they would be very little better, and may even be worse, than a lay member of the public," said Dr. Jeremy Saunders, consultant physician at the Bedford General and one of the authors of the study. "Sometimes a bit of knowledge can be harmful."

Dr. Saunders said only half the consultants in the hospital had responded to the invitation to demonstrate their skills but the rest were "unlikely to be better." The level of performance was likely to be the same elsewhere, he said.

In hospitals, junior doctors are mainly involved in resuscitation because they are on the spot when most crises occur. Their performance, however, is little better. A study of 31 newly qualified doctors last year showed that fewer than half were capable of reviving someone who had collapsed effectively.

But there is hope. After two hours training, two thirds of the Bedford General consultants had improved their skills so much they scored maximum marks and none scored zero. Regular refresher courses are needed, the study's authors say.

Is there  
a passer-by  
in the house?





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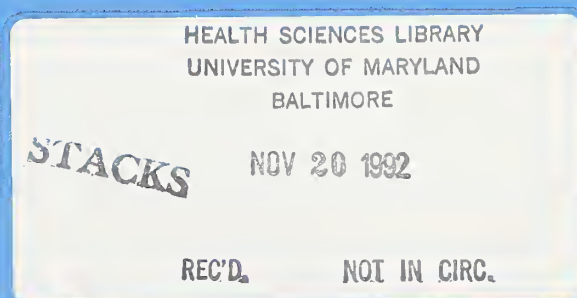


# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

ber, 1992

Volume 89, Number 11



Copic  
Decade 2

## In the age of corporate takeovers... What about Copic?

**CMS members and staff get answers to tough questions and dispel rumors (see pg. 404)**

### In This Issue:

- Living With Health Care Reform ..... *Leigh Truitt, MD, CMS President*  
CMS Leadership Conference—The Future Physician ..... *Carol Walker, El Paso County Medical Society*  
Good Medical Records Reduce Risk ..... *Bruce C. Richards, MD, and George O. Thomasson, MD*  
What is the Procedure Code for Pedioscopy? ..... *Roger C. Shenkel, MD*



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K. Mason Howard, M.D.  
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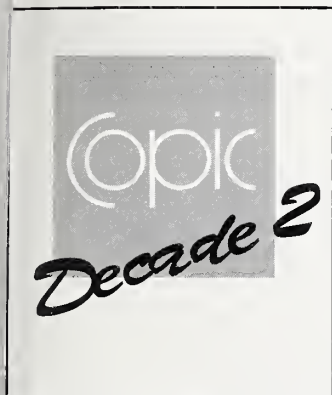




# COLORADO MEDICINE

November, 1992

Volume 89, Number 11



## Cover Story

A lot of history has gone under the bridge in the last decade. Begin on page 404 to find out why things are the way they are...



## DEPARTMENTS

- 387 President's Letter
- 389 Executive Director's Update
- 391 Inside CMS
- 396 Committee Update
- 402 Health Care Policy
- 412 Health Care Financing
- 413 Health Department
- 416 Medical News
- 417 New Members/In Memory
- 418 Ruminations
- 419 Classified Advertising

## In This Issue...

- 385 **Living with Health Care Reform**  
*Leigh Truitt, MD*  
*President, Colorado Medical Society*
- 392 **The Physician in the Year 2000—1992 Leadership Conference**
- 398 **Medical Records** can help you, or get you in trouble  
*Bruce C. Richards, MD, and*  
*Goerge O. Thomasson, MD*
- 402 **Locum Tenens:** New CMS Program
- 404 **Is Copic Ripe for a Hostile Takeover?**
- 406 **National Data Bank Response Association**  
*Special AMA Report*
- 409 **Pedioscopy:** Wave of the Future?  
*Roger C. Shenkel, MD*
- 410 **The Interview:** A Resident Checks Out the Field  
*Joe Batuello, MSI*



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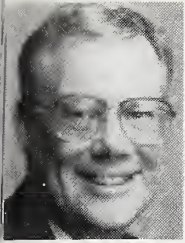


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Leigh Truitt, MD  
President, 1992-1993

## Living With Health Care Reform

On October 6th I responded to an invitation to present to the Mountain States Employers Council the physician perspective on ColoradoCare. Present were Governor Romer, his health policy advisor, a representative of a large employer and a small employer, an actuary, an insurance broker, a third-party administrator and the CEO of the Colorado Hospital Association. A feasibility study is just beginning in Colorado for the implementation of this "managed competition" health care reform. Everyone present at this meeting had concerns of one form or another about this plan.

I recounted how Colorado Medical Society had held ten health care reform forums throughout the state. I described how these discussions had been distilled into CMS Resolution 74-P, modified by the Board of Directors, further refined by a Reference Committee and finally approved as CMS policy by the House of Delegates at the Annual Meeting in September.

After outlining this CMS policy at the Mountain States Employers Council seminar, I specifically pointed out those aspects which conflict with the structure of ColoradoCare. They are substantial.

Almost every major health care association has created a health care reform proposal. Some CMS members have suggested that we need to create our own.

I believe this would be difficult and, ultimately, pointless. Our course so far has been quite valuable. We have created a **benchmark:** positions on specific aspects of health care reform that our members think important. Some of them are quite radical; for instance, the statement that our country should have universal health insurance coverage. Others reflect the majority philosophy that independent medical practice, fee-for-service reimbursement, free choice of physician, and access to all patients must be retained.

We are realistic. We know that the forces driving health care reform may override our legitimate concerns and restructure medical practice in ways that are unacceptable to us at this time. I believe that our best chance to preserve those features of our profession which we value -- those incorporated in Resolution 74-P -- is to reserve our options. This is not a passive position. We must be alert to every significant proposal; to analyze not only the stated features of these proposals, but also to understand the implications of structural changes in medical practice.

To this end I will be proposing at the November 20th Board meeting that the CMS create a task force, under the direction of the Board, to evaluate all serious health care reform suggestions (especially all

*"We have created a **benchmark:** positions on specific aspects of health care reform that our members think important."*

legislative proposals) that have the potential of implementation. This evaluation will include not only the specific features that affect medical practice, but also an analysis of how they might change our profession in the long run. It will also include a comparison with our benchmark -- Resolution 74-P. Corky Butler, Sandi Maloney and everyone else who participated in this process have served us well.

We may need to use outside experts to help us understand how proposals will affect our practice. Most definitely we will need to have a broad range of our membership on this task force, including representatives from fee-for-service, managed care, workers' compensation, public service, teaching and other forms of practice. We must not only react to significant health care reform proposals, but must also continue to refine our own policy.

We will have to make choices. It is unlikely that we will agree with all aspects of health care reform, just as we do not agree with all features of ColoradoCare. At the same time, we cannot refuse to play if this is the only game in town. If we join the discussion we can significantly influence the rules of the game. Our best chance is to determine what we value in our profession, to understand the implications of any proposed health care reform on our profession and our patients' well-being, to participate in all deliberations, to present our views forcefully, and to make the right choices when necessary. These choices must be in the best interests of patients, physicians and society.

I hope you will have read this before the next Board of Directors meeting. Please communicate your views to your Board members so that you may be properly represented.

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by *Montgomery Little Young Campbell and McGrew, P.C.*

legal counsel to the Colorado Medical Society

## Seminar On Continuous Quality Improvement

The Colorado Medical Society is pleased to sponsor an informative seminar focusing on Continuous Quality Improvement, (CQI). This one-day event is titled **CQI: A Hospital/Physician Joint Venture** and will take place on Friday, January 15, 1993 at the Hyatt Regency DTC from 9:00am - 4:00pm.

The CQI seminar will feature presentations of CQI programs currently in place at St. Mary's Hospital and Medical Center (Grand Junction), Parkview Episcopal Medical Center (Pueblo) and Penrose Hospital in Colorado Springs.

Lunch and a wine/cheese reception following the seminar are included in the \$75.00 registration fee. For more information see the December issue of Colorado Medicine. An Informative seminar brochure will also be sent to all CMS members.

## Colorado Physician Gets National Leadership Award

**Bruce H. Wilson, MD**, Medical Director of Rocky Mountain HMO, headquartered in Grand Junction, has been awarded the **1992 Medical Director Leadership Award** by the American Medical Care and Review Association (AMCRA). The award was presented at the AMCRA annual conference in San Diego. The award recognizes a medical director who has demonstrated leadership and commitment to the goals of managed health care.

Dr. Wilson has served as the full-time Medical Director at Rocky Mountain HMO since 1986. He also is the Vice President of Rocky Mountain Health Management Corporation. Before joining Rocky Mountain HMO, Dr. Wilson was in private practice in Internal medicine. He also served on the Colorado Board of Medical Examiners in the 1980s. He is now the President of the newly formed Grand Valley Hospice.

## PMA Drug Program For Indigent Patients

On July 24, 1992 the Pharmaceutical Manufacturers Association (PMA) implemented a pilot program to help physicians more easily identify and contact prescription drug company programs that provide free medicine to needy patients.

The PMA is a nonprofit scientific and professional organization of about one hundred member companies who discover and develop most of the prescription drugs used in the United States. PMA stresses that the program is designed as "an indispensable safety net for the neediest patients" and is not intended "to solve the larger national problem of access to medical care, including prescription drugs."

Since prescription drugs will only be supplied based on medical information from doctors, patients in need may apply only through a physician.

The PMA program is the formalization of a long-standing tradition within America's pharmaceutical research industry of providing free medicines to physicians whose patients might not otherwise have access to necessary medicines, according to Gerald J. Mossinghoff, President of PMA.

All of the 59 pharmaceutical companies with on line programs are listed in the PMA handbook, available to physicians only, **1992 Directory of Prescription Drug Indigent Programs**. Copies may be obtained by writing to: **1992 Directory of Prescription Drug Indigent Programs, Pharmaceutical Manufacturers Association, 1100 Fifteenth Street, N.W., Washington, D.C. 20005**. Alternatively, physicians may call the hotline number: 1-800-PMA-INFO.

When physicians provide the operator with the name of the prescription medicine they require, the operator will refer physicians to the appropriate company programs.



## Med Fax: Medico-Legal News

by Karen B Best Esq., an associate  
with Montgomery, Little, Young,  
Campbell and McGrew, P.C.

*This column is not legal advice, but is for general  
information only. For help with specific problems,  
readers should consult an attorney*

### OSHA Inspections: Rights of the Physician Office Lab

If the OSHA Inspector comes knocking, do you have to let him in? No, not unless he has a search warrant. Physician office labs (POL) are entitled to the same constitutional protection from warrantless searches as ordinary citizens. As the Agency steps up its surprise POL Inspections, knowing this right and others may save you.

An OSHA Inspection is not necessarily for all purposes. You can ask the inspector to specify exactly what he wants to look for, and the inspector may agree to limit his investigation to those areas. However, if you resist, the inspector may seek search warrant allowing blanket inspection. Although the Inspector may agree to a limited inspection, he can nonetheless cite violations uncovered during the inspection, even if the violation is not specified in the pre-inspection agreement. For example, if an inspector agrees to search the premises for bloodborne pathogen regulation violations and discovers an overloaded electrical outlet, you can and will be cited for the safety violation.

The physician-patient privilege has not been eroded. OSHA regulations relate to the health and safety of POL employees and are not directed at patient care, per se. If an inspector asks to look at confidential patient records of non-employees, you may and in fact must refuse. Only if the Inspector has a subpoena for the inspection of non-employee patient records should these records be made available. Even when the inspector presents a subpoena, you may have grounds to resist the inspection, as ordinarily inspectors have no reason to look at this information. Inspectors do, however, have every right to review employee medical records.

You may accompany the inspector while he carries out his inspection. If you are too busy to accompany the inspector on his inspection, you may ask the inspector

to schedule a return visit at a time when you are not busy. The Inspector is not required to, and probably will not, honor your request for a scheduled visit. OSHA's right to conduct unscheduled, surprise visits is a powerful weapon in its enforcement efforts. Even if the inspector agrees to return at a time when you are available to accompany him on the inspection, the inspector will probably request interviews with employees in private. If so, you cannot be present for the interviews under any circumstances.

You have the right to ask an employee to accompany you and the inspector. Good idea. You now have two witnesses to the Inspector's one. Pick someone who will be able to present your side of any dispute in a credible, knowledgeable and intelligible manner. The word of a third-party witness will carry more weight than your word alone against that of the Inspector. If the lab is unionized, a union worker would want to observe the inspection, and would hold the interests of the employees paramount to the interests of the lab. That person would present as an unbiased witness, which is what you want.

Take notes. Ask questions. Write down what the inspector says. Better yet, make sure your lab is in compliance with OSHA regulations so you won't have to worry about your rights during the inspection. If you are a party to a discussion with the inspector, you may tape record the conversation without violating state or federal laws. If you obtain consent from the Inspector before recording the conversation, you will have fewer problems later when you try to use the tape and won't have to worry about whether you are violating any laws. Record the Inspector's acknowledgment and consent to the recording. It may or may not be used at a later hearing, depending upon other factors.

Ask to copy the Inspector's report before he leaves the lab. It will come in handy if the Inspector contemporaneously records no violations. Most likely the inspector will meet with you at the end of the inspection to discuss any preliminary findings. There may not be a report available at that time because test samples and documents may have to be reviewed before the inspector can reach final conclusions. A clean bill of health at the end of the visit is no guarantee.

A word for the wise: If the Inspector points out a violation, fix it during the inspection if at all possible. OSHA regulations allow reduction of penalties when employers use good faith in their efforts to comply. Fixing a violation on the spot shows good faith.

*Continued on following page...*



## Bloodborne Pathogen Regs, Tips on Compliance

SHA'S bloodborne pathogen regs are intended to protect employees from exposure to hepatitis B and IV. They apply to hospitals and other facilities, including physician office labs. Here are some tips on how you can comply with the regs, protect your employees and avoid stringent penalties:

Keep food and drink away from areas where they might become contaminated with blood or other body fluids. Don't put drinks or food in the same refrigerator or cabinet used for blood specimens. Don't allow employees to take their food or drinks into treatment or testing areas, even if there are no patients present.

Take steps to change employees' habits. Require them to wear face shields and other protective garments when they draw blood from children. They tend to move when stuck with needles, increasing the chance of free blood splashing onto the employee. Require employees to wear full protective clothing when stitching up wounds.

The regs say that it's time to change clothes when blood or other fluids seep through the employee's lab coat or other outer wear. Ask employees to keep an extra uniform or change of clothes at the office so they can change when this happens. Some consultants recommend using the "squeeze" test in determining whether it's time to change clothes: Change if blood or liquid drips off the clothes when squeezed. Frankly, although I'm not an OSHA inspector or consultant, I would prefer the "seep" test: If it seeps through, the clothes come off.

Consider all employees when deciding who is at risk of exposure and should be included in the exposure plan. For example, if the receptionist is sometimes asked to clean up vomit in the waiting room, make sure he or she is vaccinated against hepatitis B and trained in handling infectious material. Some will argue that OSHA does not require vaccines and other protection

for employees who only receive "incidental exposure" on rare occasions. This is true. You are not required to provide vaccines and other protection to these employees, if you can prove that the exposure is "incidental" and rare. You can make a good case of showing only incidental exposure if you can document that no one threw up in the waiting room during the last six months.

Consider different scenarios when deciding who is at risk of exposure and should be included in the exposure plan. If a secretary handles vials that can be dropped onto a hard floor, that secretary is more likely to be exposed than a secretary working in a carpeted office where vials are kept in styrofoam containers. Consider the likelihood that the vial could break, or the infectious material would otherwise come in contact with workers.

Document your reasons for including or not including each employee or class of employees in the exposure plan. Be able to show OSHA that you've thought about it and tried in good faith to comply with the regs.

Although not required by the regs, good sense would dictate that you notify other employers if their employees are at risk of exposure. For example, if the building janitor is called to clean up when a patient vomits in your waiting room, notify the janitor's employer of its obligation to protect its employees by offering vaccines and other protection. Offer temporary help training in your on-site procedures, and notify the temporary agency that its employees need vaccines. Go the extra step to prevent exposure of others who may be unwittingly exposed.

Ask new employees to provide copies of their vaccination/medical records. If the employee has already had some or all of the series of hepatitis B vaccines, you can cut your vaccine costs.

Keep in mind that OSHA inspectors looking for violations of bloodborne pathogen regs can fine you for non-compliance with other OSHA rules, such as failure to keep a record of workplace injuries. Be careful out there.

# CMS Med Fax

*Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.*

## **Colorado Department of Health**

### **Hispanic Health Issues Conference**

December 4&5, 1992

Sheraton Hotel

Colorado Springs, CO

Deadline for registration is November 16, 1992

(LARASA) (303) 839-8300

### **Prosper Meniere Society**

Diagnostic & Rehabilitative Aspects of Balance & Movement Disorders

December 2-6, 1992

Denver, CO

Jane Wells (303) 788-4230

### **American Medical Association Hospital Medical**

#### **Staff Section Twentieth Assembly Meeting**

December 3-7, 1992 Opryland Hotel

Nashville, Tennessee

(312) 464-4754 or 464-4761

### **Medical Education Resources**

Coronary Heart Disease Update

Las Vegas NV

December 4-5, 1992

(303) 798-9682 or 1-800-421-3756

### **Medical Education Resources**

Asthma and Allergy in the 1990s

Key West FL

December 4-5, 1992

(303) 798-9682 or 1-800-421-3756

### **Medical Education Resources**

Asthma and Allergy in the 1990s

New York NY

December 11-12, 1992

(303) 798-9682 or 1-800-421-3756

### **University of Colorado School of Medicine**

Advances in Pelvic Surgery

Denver Co

December 11-12, 1992 CME credit

1-800-882-9153 or (303) 270-6761

### **Stanford University Medical Center**

Holiday Imaging Update

Aspen, CO

December 28, 1992 — January 1, 1993

Dawne Ryals, (404) 641-9773

### **American College of Cardiology**

24th Annual Cardiovascular Conference

Snowmass, CO

January 11-15, 1992

1-800-257-4739

### **USD School of Medicine**

Nephrology Update In Clinical Practice

January 14-15, 1993

Rushmore Plaza Holiday Inn

Rapid City, SD

(605) 339-6790

### **University of Colorado Health Sciences Center**

Reconstructive Surgery Of The Hip and Knee

CME credit

Tamarron Resort, Durango Colorado

January 23-30, 1993

Joann Bauer 1-800-882-9153

### **American Diabetes Association, Colorado Affiliate, Inc.**

30th annual Colorado Diabetes/Endocrine Institute

Presenting Highly Scientific Didactic Lectures and

Panel Discussions on Diabetes and Endocrinology

January 23-30, 1993

Aspen-Snowmass, Colorado

(303) 778-7556

### **Michigan State Medical Society**

Risk Management-Safeguarding the Future

Keystone Resort, Colorado

February 2-6, 1993

(517) 336-5757

### **University of Colorado School of Medicine**

Principles Of Anesthesia Technology

February 26-March 1, 1993

Radisson Resort Vail, Vail, Colorado

CME credit

Joann Bauer 1-800-882-9153

### **University of Colorado School of Medicine**

Crash '93- Colorado Review of Anesthesia

February 27 -March 5, 1993

Radisson Resort Vail, Vail, Colorado CME credit

Joann Bauer 1-800-882-9153







Sandra L. Maloney  
Executive Director  
Colorado Medical Society

## Health Care Reform and Workers' Comp: the Odd Couple?

### Workers' Compensation!

Sometimes the subject is enough to make you want to go home and go to bed (and sleep). Other times, it's as if a light goes on and things begin to happen with seeming reason.

That's sort of the way it was at the October 13 meeting of the CMS Workers' Compensation Advisory Committee. The committee reached a consensus on a recommendation to the CMS Board of Directors regarding a state-wide uniform fee schedule, employer designation of providers and the declaration of temporary and permanent disability; which of these aspects need to stay in a separate program and which should be blended into the larger system? There was, of course, much discussion of the cost of the system, principally that 5% of the cases represent 85% of the total cost. As committee chair, **Dr. Tash Bernton**, said, "About half of those patients you cannot readily identify the physical cause of their ills. We've got about 40% of the total cost of the system in delayed-recovery types of patients without identifiably related causes for their problems." Bernton went on to say, "I think we've done a pretty fair job in educating ourselves and other physicians in this state who deal with occupational medicine and how to effectively take care of these patients." He added that if the worker's compensation system just disappears, these patients will simply be integrated into the larger medical population, and "are they going to get better care or worse care, more expensive care or less expensive care?"

**Dr. Leigh Truitt** pointed out that

under the CMS Res 74-P which deals with health care reform all such programs, with the exception of Medicare, will be included under the CMS proposal. He stated that the economics of health care are such that you cannot separate out areas of care (typical of what Medicare has done, taking up 30% of the health care budget) without further complications in a reform proposal. Therefore, Dr. Bernton felt it reasonable that the Workers' Compensation Advisory Committee bring forth a proposed policy to the Board of Directors which would (we hope) clarify the physicians' position on what should be maintained if the present Workers' Compensation program is integrated into a larger, statewide system. That's a mouthful, but it is meaningful information.

The Committee selected **Drs. Bernton** and **Fred Groves** to present this policy to the CMS Board November 20th, and **Dr. Henry Roth** was selected to serve on the Health Care Reform Task Force being proposed by Dr. Truitt.

**What does all this talk mean?** It means that CMS membership is coming to grips with putting realistic terms to the proposed health care reform program. Congratulations to you all! Outside influences have kept warning you, threatening you, attempting to bribe you, chewing away at your professional status and your ability to make independent clinical decisions. It is this kind of reality process which must be practiced within organized medicine to preserve the proudest profession and the health and safety of your patients. Please... Keep it up!

*"I think we've done a pretty fair job in educating ourselves and other physicians in the state..."*

## Nephrology Update in Clinical Practice

January 14, 15, 1993  
Rushmore Plaza  
Holiday Inn  
Rapid City, SD

Fourth Annual  
Conference Sponsored  
By:  
Department of Internal  
Medicine,  
USD School of Medicine  
and  
Rapid City Regional  
Hospital

### Program includes:

1. Acid/base symposium
2. Common nephrology lab tests review
3. Symposium on renal diseases in the extremes of age
4. Symposium on dialysis and transplantation
5. Clinical/pathologic review of common glomerular diseases
6. New drugs in renal patients/detoxification

Physicians, Nurses,  
Pharmacists, Students,  
Dialysis Nurses &  
Technicians, Dieticians  
Welcome

### Contact:

Pat Sivesind, Registrar  
Department of Internal Medicine  
USD School of Medicine  
PO Box 5046  
Sioux Falls, SD 57117-5046  
Phone (605) 339-6790

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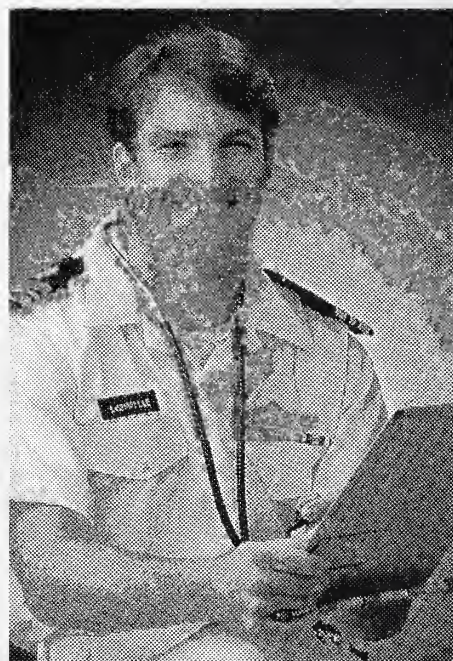
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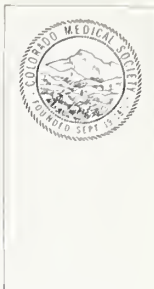
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## CMS announces new member financial service

Effective October 1, 1992, the Colorado Medical Society began a relationship with the Chase Manhattan Bank through the **Physician's Financial Program**. This program brings the power of Chase Manhattan to the individual physician members for personal and business finances. You will see, in this issue, a description of the program with a reply card for further information on the variety of services included in the Physicians Financial Program.

Colorado Medical Society Member Services went out into the market seeking the best financial program offered by a commercial bank, and this program was chosen for its all-round service and low costs.

The **Physician's Financial Program** is not an annual fee or subscription program; if you are a member in good standing of CMS you are eligible to use the Physicians Financial Program and many of the financial services provided are free or at a substantial discount from market prices. The purpose of this program is to provide members of CMS with qualified, unbiased financial advice, superior service and reduced costs in the areas of home mortgages, equity lines of credit, educational debt refinancing, tax planning and strategies, financial planning, estate planning, trust services, portfolio analysis/investments, retirement plans, auto financing and advice and service in all areas of finances.

The program will be providing CMS members with regular financial seminars and reports; each physician participant will be able to access the system for inquiries and program information 24 hours a day, seven days a week by telephone to the Chase Manhattan information center; all inquiries will be handled by the Chase professionals based in Denver.

The Home Mortgage/Equity Lines of Credit program (loan amounts of \$300,000 to \$1 million) includes free mortgage analysis consultation, 72-hour loan approvals, pre-approvals on mortgage applications, preferential interest rates, reduction in closing costs, no tax and insurance escrows, free home equity line of credit (behind Chase first mortgages) if equity permits, and free Gold Visa card (no annual fees).

This member service program has taken nearly a year to be assembled and approved by CMS. CMS Executive Director Sandi Maloney said "It's like having a branch of Chase Manhattan at CMS, devoted solely to our member's needs."

Watch for the information and offers in the mail; look for the seminar announcements and if you have immediate questions, call 1-800-223-2140 for the CMS **Physician's Financial Program**.

*"It's like having a branch of Chase Manhattan at CMS, devoted solely to our member's needs."*

# CMS Leadership Conference

## The Role of the Component Society

Carol A. Walker  
July 12th

### *Component Societies are the "Elmers"*

I've been a local medical exec for over 15 years and we always call ourselves county or component societies. Never during that time have I heard us called Elmers...But, that's what I think the name for a local society should be. Component medical societies are the glue that holds organized medicine together. Each piece of this federation has to contribute what they do best for the mutual benefit of all. Elmers are where the bonds of the profession are proven each and every day.

#### ***Component societies provide many intangible benefits***

In no other organization do all the varying interests of medicine and types of practice come together as equals; where issues of mutual concern are hammered out by fee for service physicians, salaried & contract physicians, private practice/public practice physicians, clinicians/administrators/academicians in every major specialty by every age category, both genders, American trained and FMGs.

In other words, components are the greatest common denominator of the profession.

In all levels of the federation a few members do a lot of work for all of medicine. We have a very viable and energetic society in El Paso County. I believe our great member participation makes it that way. But, did you know that physicians comprise less than one quarter of one percent of the total population? That's not a lot of people to do all the work that we expect to get done! Especially when you consider assortment of entities petitioning for

your time and attention. In fact, can you personally remember the last time that the only thing you had to do was to practice your profession?

More and more you're fragmented by hospital medical staffs, competing clinics, managed care plans, medical specialties, and subspecialties. Now payment systems are starting to drive wedges between specialties which can then be used to everyone's advantage except yours.

County medical societies are the personal and most closely tied gatherings of physicians. It's the only place all physicians can come together as equals on a day to day basis without being put in a competitive situation.

#### ***Components provide a lot of tangible benefits***

You'll need to take a deep breath here if you want to keep up cause to get through just a partial list of all the benefits I'm aware of I'm going to have to really accelerate!, worker's comp insurance programs, payroll service, practice management seminars, referral service, negotiations, telephone answering/radio paging services, placement service, monitoring & reporting of Medicaid, Medicare & HCFA issues, institutional review boards, newsletters & magazines, you have the ability to register to vote at general membership meetings, some great meals (and maybe some not so good), centralized credentials verification, discounted medical, surgical, capital equipment and office products, medical employee contract leasing, auto leasing/banking services,



# "The Physician in the Year 2000"

cellular phones, employee handbooks, safety prescription pads, insurance plans of all types, we address labels and provide announcements, and physician directories are always in demand.

In fact, in a national survey they've found that county medical society rosters are used far more often than all other reference sources for referrals, consults and other business and social networking and, we have libraries and meeting rooms for your use.

Medical execs have two wonderful avenues for networking. These help us tremendously to be as effective as possible. One is through our national organization, called AAMSE, and the other is our own statewide execs organization. As you can tell from the list above, we share a lot of great ideas ... Now if we only had the time and money to take advantage of all the creative thinking!

The Colorado Medical execs organization is probably the best intangible member benefit you receive. We share ideas, problems and lots of solutions and when we face one more irritated patient, disappointed doctor, or frustrated staff member we know we'll remember why it's all worthwhile the next time we have one of our meetings.

## ***County societies do for members what they individually can't do for themselves***

we are physician advocates with the Wews media, local employers, community organizations, other health related organizations, hospital medical staffs, city and county

government, school districts, legislators, office managers, state, national and other county societies and sometimes even with your spouses through the great auxiliaries we have.

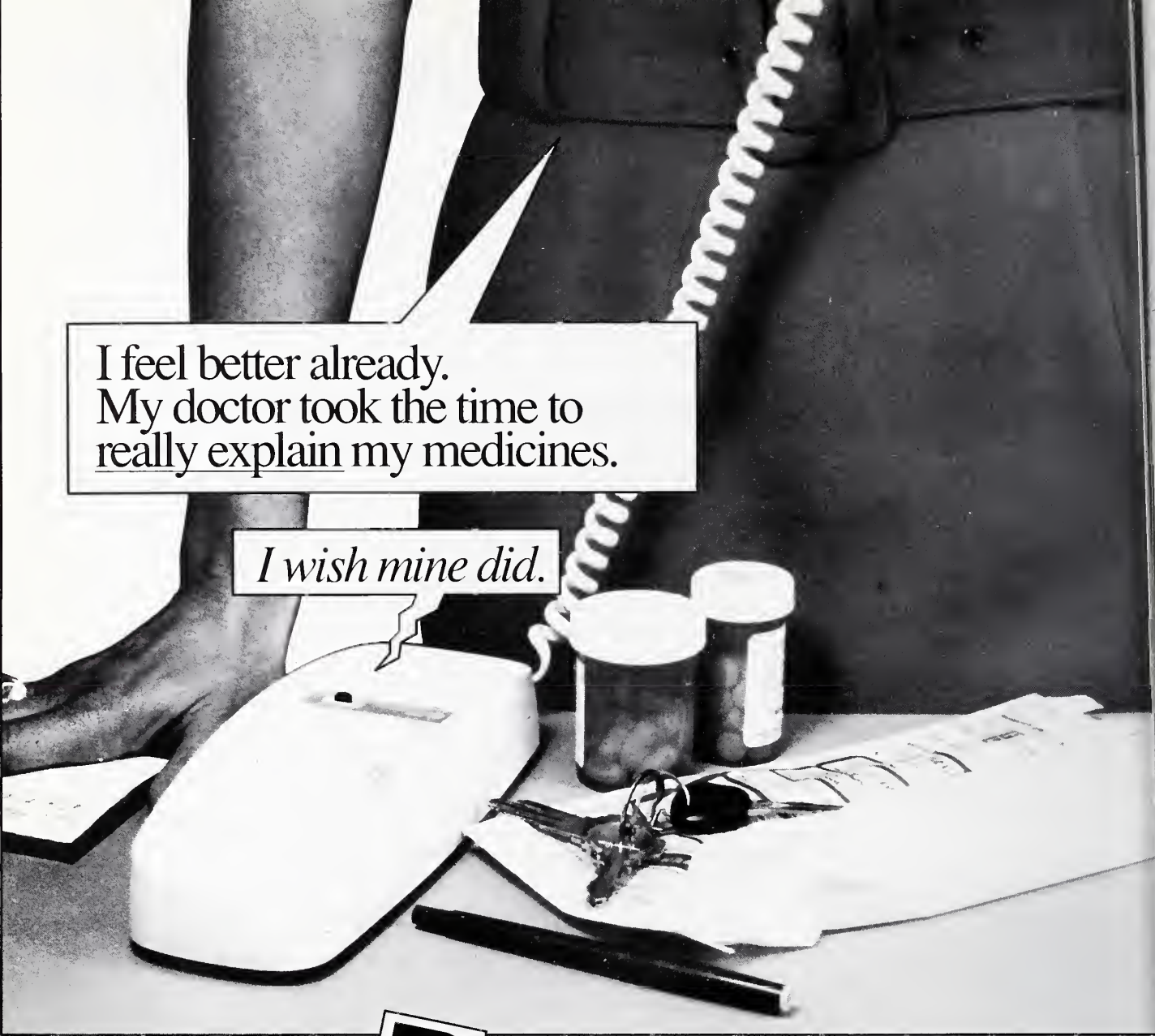
As an example of this advocacy; the members of our society got fed up with hearing that they didn't contribute to their community. In order to begin to modify this image they formed the EPCMS Foundation. Each member is expected to contribute \$100. Their contributions are then used to fund grants to local organizations. In this way we can help our community and also the doctor image in our area.

***Local societies are patient advocates through*** referral services, grievance committees, mini-internship programs, speakers bureaus, adopt a school programs, disaster assignments, team physician work, immunization clinics, child safety programs & child protection programs, AIDS committees, medically indigent programs, blood banking & trauma resources, and even county health departments

We Elmers provide a place where new doctors can become acquainted with the practicing community and we give long time members a convenient place to meet friends, share information and find answers to their practice questions and problems (around our office my staff tells me that they receive hundreds of calls each day from doctors, patients and medical office staffs; I think that might be stretching it a little, but I do know we get lots of fascinating and unique calls!)

*"[W]e can help our community and also the doctor image in our area."*

*Look for more of this exciting story in next month's issue...*



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**P**

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State

Zip







## Letter from the Members

We just want to say "thank you" to a member of CMS who has probably contributed as much or more of his personal time (without remuneration) to the Colorado Medical Society as any member in the CMS history.



**Donald W. Parsons, MD**, has been on the spot when CMS needed him in a public, legislative, council, committee, participant, panel member, and a wide variety of tasks. Don Parsons has been an extremely effective leader in a variety of council and committee positions. He has been a member of his local and state medical societies for the past nineteen years. During that time, Don served on the Medically Indigent (MI) Committee of the Denver Medical Society until 1985, and then went on to become a member of the CMS MI Committee in 1986, and then chairman until his departure. During that same time he was active in the DMS Legislative Council and was a member and Chairman of the CMS Council on Legislation.

We thank Dr. Parsons for testifying on behalf of the DMS and CMS policy before countless legislative reference committees.

Dr. Parsons becomes the national legislative representative for Kaiser Permanente in Washington, D. C., this month, but will maintain his CMS membership. Colorado Medical Society wishes Dr. Donald W. Parsons "bon voyage".

*Bon Voyage, Don!*

# Ouch!

*"My bookkeeper neglected to back up the office computer's hard disk, and a power surge wiped clean our patient master file. It cost us \$5,000 to re-input all the data . . ."*

*"Backups were performed diligently every night in our office, but no one knew that the backup device was not working properly — until a computer 'virus' destroyed all our billing records . . ."*

*"While trying to format a floppy disk, a new employee accidentally reformatted our hard disk instead. We had to spend over \$3,000 for a high-priced computer consultant to re-install our software and retrieve all our lost data . . ."*

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*A monthly report of current and on-going activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

#### November, 1992

The next meeting of the **COMMITTEE ON ACCREDITATION** will be held on Thursday, November 5, 1992, at 4:00 p.m. at the CMS offices.

The **COUNCIL ON PROFESSIONAL EDUCATION** will meet on Thursday, November 19, 1992, at 4:00 p.m. at the CMS offices.

Here are the tentative meeting dates for the coming year. These have not yet been confirmed.

#### Committee on Accreditation

November 5, 1992  
February 4, 1993  
May 6, 1993  
August 5, 1993  
November 4, 1993

#### Council on Professional Education

November 19, 1992  
February 18, 1993  
May 20, 1993  
August 19, 1993  
November 18, 1993

## 1992-1993 Practice Management Workshop Schedule

- |  |   |
|--|---|
| November 16  | <b>Animals in Research</b>  |
| one-day workshop presented by AMA, co-sponsored by CMS and UCHSC   |   |
| December 4   | <b>Transition from Training to Practice</b>   |
| one-day workshop designed especially for interns, residents, fellows presented by Practice & Liability Consultants |   |
| January 14   | <b>Improved Collection Practices in the Health Care Office</b>  |
| one-day workshop (half-day general session; half-day technical session) presented by I C System, Inc.              |   |
| February 24  | <b>Retirement Planning - How to Close Your Practice and Enjoy Financial Security</b>                                    |
| one-day workshop presented by Practice & Liability Consultants   |   |
| February 25  | <b>Buying and Selling a Practice</b>  |
| one-day workshop presented by Practice & Liability Consultants   |   |
| March 18   | <b>HMO/PPO Contracting: Avoiding Pitfalls... Attaining Profits</b>  |
| one-day workshop presented by Practice & Liability Consultants   |   |
| March 19   | <b>What Medical School Didn't Teach You About the Business Side of Your Practice</b>                                    |
| one-day workshop presented by Practice & Liability Consultants   |   |
| April 21   | <b>Improving Third Party Coding &amp; Reimbursement</b>   |
| one-day workshop presented by Conomikes Associates   |   |
| April 22   | <b>Fee Analysis and Claims Analysis</b>   |
| one-day workshop presented by Conomikes Assoc.   |   |
| May 19   | <b>Maximize Your Profits - A Blueprint for Effective Billing and Coding in the Medical Office</b>                       |
| one-day workshop presented by Practice & Liability Consultants   |   |
| May 20   | <b>Marketing in Health Care - Internal and External Strategies</b>  |
| one-day workshop presented by Practice & Liability Consultants   |   |
| June 8   | <b>Reception and Patient Flow Techniques</b>  |
| half-day workshop presented by Conomikes Associates  |   |
| June 8   | <b>Better Collections, Billing and Insurance Techniques</b>   |
| half-day workshop presented by Conomikes Associates  |   |
| June 9   | <b>Protecting Your Medical Practice: The Embezzlement Problem - Controlling Internal Fraud and Abuse</b>                |
| half-day workshop presented by Conomikes Associates  |   |
|  | <b>Medical Office Management Institute (MOMI)</b>   |
|  | <i>discounts available for one person attending all four or four people from the same office attending one workshop</i> |
| August 17  | <b>Effective Personnel Management Techniques</b>  |
| one-day workshop presented by Conomikes Associates   |   |
| August 18  | <b>Improving Your Managerial Effectiveness</b>  |
| one-day workshop presented by Conomikes Associates   |   |
| August 19  | <b>Patient Flow Management</b>  |
| one-day workshop presented by Conomikes Associates   |   |
| August 20  | <b>Financial Management</b>   |
| one-day workshop presented by Conomikes Associates   |   |





# Peak Performance

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# Medical Records Figure Prominently in Malpractice Cases

## A Closed Liability Claims Analysis

Bruce C Richards, MD, and  
George O. Thomasson, MD

*"[T]he 40 highest-paid claims (11.3%) accounted for 88.7% of the total dollars spent....Five doctors represented the top 13 claims among those highest 40."*

An analysis of 353 closed claims involving obstetrician-gynecologists revealed that the 40 highest-paid claims (11.3%) accounted for 88.7% of the total dollars spent. Newborn obstetrics, maternal obstetrics, and delayed-diagnosis claims represented 80%. Five doctors represented the top 13 claims among those highest 40. Only one of these physicians is still in good standing with the insurance company. Twelve claims (30%) were judged to be nonmeritorious, resulting in indemnity in five cases. Most of these claims illustrated either deficits with the medical record or system failures and not regarding the medical record as a legal document. Lawsuits occasionally resulted in an unfair distribution of dollars to injured parties and led to justifiable restriction of few physicians. It is critical that there be a record of why something was done. If the record is silent, there is no defense. An erroneous decision may be defensible if the reasons leading to it are recorded in the chart. (*Obstet Gynecol* 1992; 80:313-6)

In 1987, tort costs in the United States were \$117 billion. This dollar amount has increased 300 times during the past 57 years and represents 2.5% of the gross national product. This is three to eight times the cost of tort systems in other areas such as major European countries, Australia, and Japan (*Tort cost trends: An international perspective*, 1985, Tilling-hast, a Towers Perrin Company; original study by R. W. Sturgis presented to the American Insurance Association). These runaway tort costs in the United States are re-

flected in the large insurance premiums paid by obstetrician-gynecologists and the "malpractice crisis."

In 1990, an ACOG survey showed that 77.6% of obstetrician-gynecologists have been sued at least once.<sup>1</sup> Although it is obvious that most of these doctors are not incompetent, the results of this litigation have been devastating. Because of the high rate of lawsuits, 12.2% of the survey respondents no longer practice obstetrics and 24% have decreased the level of high-risk obstetric care, leaving many patients without adequate care. In 1986, 19 Colorado counties were without obstetric care, 1174 women traveled an average of 32 miles for their appointments.<sup>1</sup>

During the past 15 years, many insurance companies stopped writing malpractice insurance policies. Physician-owned mutual insurance companies emerged, including Copic (originally Colorado Owned Physicians Insurance Company). In 1986, there would have been no malpractice insurance coverage for the majority of Colorado physicians had it not been for Copic.

### **Materials and Methods**

This analysis is derived from the records of Copic. From January 1983 to April 1991, there were 353 obstetric and gynecologic closed claims in Copic's files. Forty claims with payments over \$25,000 are included, representing 88.7% of the total dollars spent but only 11.3% of the total claims. This suggests that malpractice insurance is a very low-frequency, high-risk endeavor. Eighty percent of the claims in the highest-



paid group involved obstetrics or delayed diagnoses, representing 92% of all claims expenses (Figures 1 and 2).

Of the 353 claims, 247 (70%) were closed with no payment of indemnity, 138 with no payment of indemnity or expenses, and 109 with payment of expenses only.

In the highest-paid group, 24 (60%) were resolved with a compromise settlement, suggesting a lack of confidence to go to trial; nine claims (22.5%) were prepared for trial and resulted in indemnity payments with judgments of pre-trial compromises; and seven (17.5%) had no indemnity payment because of a jury verdict, voluntary dismissal, or judgment for the physician. These seven were in the highest-paid claims group only because of expenses.

Of 147 obstetric delivery claims, 23 (57.5%) were in the highest-paid group and represented \$5,343,991 (76.5%) of the total expense. In the highest-paid claims group, 15 of the first 23 were related to newborn compromise, and 17 of the first 20 were obstetric.

Of 19 claims resulting from therapeutic abortion, only one, a hysterectomy following perforation, was in the highest-paid claims group and cost \$79,936.

Of 61 gynecologic surgery claims, only two were in the highest-paid claims group. These included a post-operative infection with colostomy and a neurogenic bladder following a radical hysterectomy, both of which resulted in no indemnity. The rest involved ureteral, bladder, and rectal injuries.

There were 15 tubal sterilization

and 12 laparoscopy claims, which included three bowel injuries (one temporary colostomy), one aortic perforation, one postoperative bleeding episode, one other artery laceration, and one abscess. One tubal ligation claim with a subsequent ectopic pregnancy was in the highest-paid claims group and was dismissed with no indemnity.

Of the total claims, there were 62 related to delayed diagnoses, 17 with breast cancer and the remainder with lung cancer, cervical cancer, Hodgkin's disease, cholecystitis, ectopic pregnancy, ovarian cyst, obstructed ureter, and others. In the highest-paid claims group, there were nine claims (22.5%) accounting for \$1,169,943 (15.9%) of the total. There were five delayed diagnoses of breast cancer and one each of cancer of the cervix, cancer of the lung, choriocarcinoma, and endometriosis.

There were nine medication claims. Three in the highest-paid group included a Stevens-Johnson syndrome reaction to trimethoprim-sulfamethoxazole, administration of oxycodone-aspirin to a patient allergic to aspirin, and enterocolitis after amoxicillin.

Twelve (30%) of the highest-paid claims were judged by the authors to be proper treatment (nonmeritorious). Seven of the 12 settled without indemnity costs, including four that went to trial with a defense verdict and three that were dismissed, leaving five others in this group with proper treatment and indemnity costs. Expenses to defend all 12 cases of proper treatment totaled over \$500,000.

*"Most of these claims illustrated either deficits with the medical record or system failures and not regarding the medical record as a legal document."*

# Malpractice Litigation and the Medical Record

*Continued...*

*"It is critical that there be a record of why something was done. If the record is silent, there is no defense. An erroneous decision may be defensible if the reasons leading to it are recorded in the chart."*

In the amoxicillin case, the Copic doctor had no indemnity but two other doctors and the hospital had very high indemnity. In the case of a death from pulmonary embolus after cesarean delivery and a voluntary uncharged delivery, Copic doctors had no indemnity but the primary care doctors had high indemnity.

There were several system failures. For example, a 27-week pregnant patient with preeclampsia saw doctor, who insisted on hospitalization. She refused and promised to return the next day. That night she became eclamptic. Her husband telephoned the doctor on call, who had not been told of her status and gave an inappropriate response. This sequence was not in her records. Had the doctors had a system informing each other of potentially dangerous cases, the medical outcome would not likely have changed, but an appropriate caring response may have prevented litigation.

Failure to diagnose breast cancer is another system failure, e.g., a dominant breast mass is not biopsied or further evaluated because of a negative mammogram. There were other system failures: A choriocarcinoma was not followed with B-hCG; the radiologist's report of lung cancer was not noticed by the gynecologic surgeon until 9 months later; and report of a positive Papanicolaou test for cancer of the cervix in a prenatal clinic was overlooked until the patient appeared at another clinic months later.

There was probably no malpractice involved in the care of the

patient with the trimethoprim-sulfamethoxazole Stevens-Johnson syndrome. However, inadequate documentation of the patient's urinary symptoms led to the highest gynecologic indemnity costs. Another record clearly showed that a pregnant patient with premature rupture of the membranes was put to bed. She was delivered 9 days later of a double footling breech with Erb palsy. Nothing in the record indicated any attempts to determine fetal maturity or position or any advance preparation for this high-risk delivery.

Another prenatal record confirmed severe preeclampsia with no recorded recognition of adequate treatment, and perhaps altered records, resulting in adult respiratory distress syndrome, disseminated intravascular coagulation, sepsis, and death.

## **Discussion**

Good doctors do make mistakes and there are errors of omission. However, there are also instances of malpractice. Of the doctors involved in the top 13 claims, five had one or two other claims in the highest-paid claims group. Only one of these doctors is still in good standing with Copic. Nevertheless, the legal system may penalize competent doctors who have not constructed their charts to serve as legal documents. The medical chart is no longer a medical document, but a legal document. Chief Justice Oliver Wendell Holmes said, "Don't be foolish, boy. We practice law, not justice."<sup>2</sup>

Previous analyses have empha-

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sized standard of care or the amount of recovery for jury verdicts versus settlements.<sup>3</sup> The emphasis here is omissions from the medical record and blatant system failures. The medical record is important in nearly every medical liability claim. Details of patient care may never be known and the doctor's testimony will frequently not be believed. Years later, plaintiff, defense attorneys, and expert witnesses will have only the medical record on which to base their conclusions as to whether the standard of practice was met.

When involved in a high-exposure case, the plaintiff's attorney may demand settlement for limits of insurance or threaten punitive damages. Avoiding such demands requires excellent records and provision of the best patient care. Humanistic concern for the patient or lack of it may be reflected in the record. A good record will abort demands that blackmail physicians and insurance companies to settle at limits.

Study of the Copic data base with cost analysis of 3205 multi-specialty claims showed an average cost per claim of \$22,584. When there were medical-record deficits, e.g., inadequate instructions, delayed entries, inadequate notes, and consent-form issues, these claims were more than double the average cost. When there were system failures, these claims nearly tripled the average cost.

Attorneys and the media sometimes contend that the malpractice crisis is due to a small number of bad doctors. Is this correct when 77.6% of all obstetricians and gynecologists

are sued? Nevertheless, there are instances of substandard care, and these data showed that five doctors in the top 13 claims had 30% of the other suits in the highest-paid group resulting from malpractice. This analysis showed that 12 patients (30%) had proper treatment. The tort system is often ineffective for differentiating between these groups. It is an inefficient compensation system when only 28 cents of every premium dollar goes to injured patients. An average delay of 4.9 years to dispose of a case benefits neither the patient nor the physician. Judges and attorneys are trained in the adversarial nature of the tort system; physicians are trained to be patient advocates. American medicine is one of the last bastions of advocacy and humanistic concern for the patient. This bulwark is being eroded.

The standard of care is no longer what was done, but why, according to the record, something was done. If the record is silent, there is no defense. If an error was made but the decision was reached through a thought process recorded in the chart, there is a defense. Many attorneys contend that if an event is not noted in the chart, it did not happen. The chart must be timely, accurate, and unchanged.

The physician should make his or her systems as foolproof as possible. The record will document whether treatment responses were timely and showed interest, concern, and caring.

*"In 1987, tort costs in the United States were \$117 billion. This dollar amount has increased 300 times during the past 57 years and represents 2.5% of the gross national product."*

#### NOTES:

<sup>1</sup> American College of Obstetricians and Gynecologists. *Professional liability and its effect: Report of 1990 survey of ACOG membership*. Washington, DC: American College of Obstetricians and Gynecologists, 1990.

<sup>2</sup> Bader L. *The justice from Beacon Hill: The life and times of Oliver Wendell Holmes*. New York: Harper Collins, 1991:608.

<sup>3</sup> Whitelaw JM. Hysterectomy: "A medical-legal perspective, 1975 to 1985". *Am J Obstet Gynecol* 1990; 162:1451-8.

<sup>4</sup> Rosenblatt RA. "An analysis of closed obstetric malpractice claims." *Obstet Gynecol* 1989;74:710-3.



*"CMS will act as a matching service..."*

### **Locum Tenens Project - Locum Tenens Application**

Physicians practicing in rural Colorado quickly describe a list of difficulties which come along with the joys of practicing in a rural setting. While the commitment of CMS alone can not create all of the changes necessary to assist rural health care, there are some things we can do.

CMS is starting a locum tenens project. We hope you will find it of service.

CMS will act as a matching service between host physicians and locum tenens. We are in the process of developing a pool of physicians interested in serving as locum tenens. If you are interested in working as a locum tenens, and have not already completed an application, please complete the form provided in this issue of *Colorado Medicine* and return it to CMS. Feel free to photocopy the form for others who might be interested.

### **HOW THE PROJECT WILL WORK -**

The application form provides the basic information necessary to match the credentials of potential

locum tenens with the requirements of host physicians. Physicians in need of the services of a locum tenens are invited to contact CMS. After receiving some basic information from the host physician, CMS will provide a list of potential locum tenens who meet the basic requirements as described. In addition, we will provide a packet of information to guide host physicians through the process of establishing locum tenens coverage for their practices. The rest is between the host physician and the locum tenens. All negotiations re: fees, lodging, practice arrangements, etc is up to the participating physicians, thereby eliminating the costly overhead and administrative fees which make other locum tenens service agencies so expensive. There is no cost to CMS members for these services.

Please photocopy and fill out the form at right, then return it to CMS if you are interested. You may mail your application to:

Locum Tenens Program  
Colorado Medical Society  
PO Box 17550  
Denver, CO 80217-0550

or FAX it to (303) 771-8657.

If you have any questions about the program, please call (303) 779-5455 (in the Denver area) or 1-800-654-5653 (outside the metro area). CMS staff will be glad to assist you.



# Colorado Medical Society—Locum Tenens Project

## Application to Serve as Locum Tenens

Name: \_\_\_\_\_ Phone No. \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Are you a CMS Member? \_\_\_\_\_

Specialty(s): \_\_\_\_\_

Medical License No. \_\_\_\_\_ Malpractice Insurer: \_\_\_\_\_

In what specialties are you residency trained? \_\_\_\_\_

In what specialties are you board certified? \_\_\_\_\_

Are you willing to assume responsibility for an OB practice? \_\_\_\_\_

Are you willing to supervise non-physician health care providers (e.g., PAs, Nurse Practitioners, etc.)? \_\_\_\_\_

Do you have any health problems which might interfere with your ability to practice medicine effectively? \_\_\_\_\_

Professional Practice History:

***Location***

***Type of Practice***

***Dates***

### Your requirements for placement:

Type(s) of practice: \_\_\_\_\_

Scope of Practice (on-call nights or weekends, EMS physician advisor, etc.)

\_\_\_\_\_

\_\_\_\_\_

Length of Assignment (Are you interested in 1 day a week on a regular basis; long term (2-3 months); 1 week/ 1-2 times per year, etc.)

\_\_\_\_\_

\_\_\_\_\_

Other:

# In the age of corporate takeovers...

*Editor's note: The makeup of the physician community in Colorado constantly changes, as does the populace as a whole. Questions arise, particularly from physicians and those they work with who are relatively new on the scene, about Copic's statutory foundation, ownership, vulnerability to takeover by outsiders, et cetera.*

*In order to provide an efficient way to surface those legitimate questions, **Copic Topics** met with and otherwise communicated with a panel of experts. Included were Dr. K. Mason Howard, Chairman of the Board of Copic; Larry Thrower, President of Copic; and George Dikeou, General Counsel and a Copic Director. Sandra Maloney, Executive Director of the Colorado Medical Society, along with the Editor of **Copic Topics** posed the questions.*

**Maloney:** I have a general knowledge about Copic's origins, but would someone please start from the beginning?

**Dikeou:** In 1977 the Colorado General Assembly enacted a statute, C.R.S. 11-70-101 et. seq., which allowed any group of physicians to establish a trust for the sole purpose of insuring against malpractice losses.

Pursuant to this statute physician insureds make annual premium payments to the Trust in exchange for malpractice insurance. These accumulated premiums become the corpus of the Trust, to be used to pay losses.

The trustees of the Trust, as fiduciaries and not as "owners" in any sense, hold legal title to the corpus and must manage it to protect physician insureds against loss.

**Dr. Howard:** In a limited sense, Copic goes back even before that. In 1973 the Colorado Medical Society initiated a program with one of the major commercial insurance carriers, The Hartford, to pool insurance premiums, maximizing buying power and establish a premium credit plan. That program continued with CMS sponsorship through 1981, providing liability coverage to the vast majority of Colorado physicians and surgeons.

In 1981 something called The Hartford/CMS Professional Liability Trust was established in an attempt to give physicians more control over their professional liability insurance destiny, but that wasn't the outcome, and so some of us began investigating the feasibility and advisability of forming a truly physician-driven

insurance company.

On June 26, 1981, under the authority of existing Colorado statute, Copic Trust, a single-state, doctor-controlled company was launched, and the following year began functioning with support from CMS of approximately \$400,000, which has been repaid.

Then, in 1984, Copic Insurance Company, wholly owned by Copic Trust, received a charter from the Colorado State Insurance Commissioner as a multi-line insurance company.

**Maloney:** Does Copic Trust still exist?

**Dikeou:** Very much so. Copic Trust might be compared to a bank's trust department which manages assets as a fiduciary.

Those assets are held for the payment of malpractice judgments and settlements and all costs associated with those payments, including defense costs, administrative costs, etc. Among the assets held to meet those obligations, current and future, are 100 percent of the stock in Copic Insurance Company, 100 percent of the stock in Copic Insurance Agency and title to the Copic Building at 7800 E. Dorado Pl., Greenwood Plaza.

It obviously is anticipated that the Trust assets will be more than sufficient to pay for all losses and expenses incurred on behalf of physicians who are or have been insured by the Trust and Copic Insurance Company.

Since the Trust still has open cases which date to 1981 it can reasonably be expected that cases relating to our 1991 policies will be open





# What about Copic?

(Part I of two parts)

well into the first decade of the next century. If, at the end of insurance business by the Trust directly, there are assets remaining in the Trust, its trustees are obligated to use such assets in a manner which shall benefit physicians in Colorado.

It is important to recognize that the trustees of Copic Trust have an ongoing fiduciary responsibility to manage Trust assets to carry out the purpose of the Trust; this is an obligation keenly felt and strongly held by them.

**Maloney:** How are the Trust and Copic Insurance Company governed today?

**Dr. Howard:** The membership of Copic Trust has, by ballot on repeated occasions, named a Board of Trustees to provide that governance, and has amended the Trust bylaws in a fashion which permits the Board to govern and to fulfill its fiduciary responsibilities to all policyholders.

In 1990 physicians who had been Copic Trust insureds voted nearly unanimously in a mail ballot that henceforth the Board of Directors of Copic Insurance Company would appoint the Board of Trustees of the Trust. In practice the two boards have the same members, and they act variously for the two closely related entities.

Our intent in the early 1980s was that the Trust would cease writing new policies, and that Copic Insurance Company would provide all coverage.

However, in 1986 Copic's principal competitors suddenly quit the state in the face of spiraling malpractice judgments and settlements, leaving 1,200 Colorado physicians

in desperate straits, and we reactivated the Trust as an insurance writer to accommodate them.

As of January 1, 1992, the Trust is once again in the process of gradually winding down its insurance operations, eventually to be left only as the holding company parent of Copic Insurance Company and Copic Insurance Agency.

**Editor:** It has just come to light that controlling interest in one of Copic's "sister" Physician Insurers Association of America carriers in Ohio suddenly, and without prior knowledge of the company staff, let alone the insureds, was being sold to another company. What about Copic? Is any Copic entity for sale?

**Thrower:** No. It is true that as Copic has grown in strength, assets and expertise, overtures have come from several sources which expressed interest in purchase or merger. Each has been firmly and flatly rejected by the Board and management.

Our company was established to solve a single problem within Colorado only, and it is not looking to being subsumed by some non-Colorado carrier, or anyone else.

The Ohio PIAA company was vulnerable because, not only was it for profit, but its stock is traded and is on the NASDAQ index.

**Maloney:** *How are the Trust and Copic Insurance Company governed today?*

(Part II will appear in the December, 1992 issue of *Colorado Medicine*)

# Special AMA Report: (NDBRA)

## If you've received a solicitation... Take another closer look!

*"The membership application requests highly sensitive information..."*

### AMA Staff Meets with "Data Bank Response Assn."

A number of state and specialty medical associations and individual physicians were part of a mass mailing this summer from an organization calling itself the "National Data Bank Response Association".

The organization promotes itself as a "counterbalance" to the federally-operated National Practitioner Data Bank (NPDB). For a \$250 membership fee, the organization will forward its physician members explanations of adverse actions (such as loss of hospital privileges) and malpractice claims to entities like hospitals that request information from, or "query" the NPDB regarding the physician.

These explanations are to be in addition to those that are allowed in the federally authorized NPDB forms.

Members of the AMA staff recently met with representatives of the Data Bank Response Association and learned that not all is as represented by the mailed solicitation.

The mailing claims that the NDBRA offers as part of the membership fee: a newsletter, lobbying support, specialty claims tracking, insurance placement assistance, quarterly tracking of any entities that query the member's NPDB file and an option of appointing the organization as the physician's "authorized agent," thereby giving the organization access to the physician's NPDB file.

For an additional fee, the organization offers a "claim/action rating" service, which purports to offer the services of a physician, trial

attorney and malpractice insurance underwriter to evaluate settled or pending cases.

AMA staff were advised by NDBRA representatives that:

- The NDBRA is not currently, as it holds itself out to be, an association.
- Some of the features the organization promotes are not in existence; i.e., it does not have currently a newsletter and does not offer lobbying support.
- The organization offers a "rating" or "analysis" of members' malpractice claims, however, the "rating" is based primarily on information received from its members, and may not be deemed credible by entities receiving it, as it may be viewed as unverified or self-serving.

Based on the meeting and a review of the organization's materials, AMA legal staff has further concerns including the following:

- It is not clear that the state peer review statute in Tennessee, in which the organization is located, offers protection for confidential information held by the organization regarding its physician members. Both the NPDB report, which the organization obtains on behalf of its members, and the information that is requested on the application require adequate confidentiality safeguards. The membership application requests highly sensitive information asking such things as whether the physician applicant has ever been charged with DWI (driving while intoxicated), has ever been investigated or charged with a felony or misdemeanor.



# National Data Bank Response Association

It is not what it appears to be.

from the AMA FedNet

Under federal law, the information in a physician's NPDB file cannot be disclosed in response to a subpoena. However, federal law does not otherwise prohibit the disclosure of NPDB information that is "otherwise authorized" under state law. Thus, information could be subject to discovery requests (as well as subject to a subpoena in the case of information included in an application) in, for example, a lawsuit alleging medical negligence.

- The organization provides an "authorized agent form" for members to "appoint" the organization as their authorized agent to obtain a copy of the physician's NPDB report, as well as to find out if other entities have requested a copy of the physician's NPDB file. This form, however, does not comply with the requirements of the federal government. Physicians who wish to use an authorized agent are required to themselves register the agent with the NPDB. The practitioner must send a letter of notification to the NPDB containing a number of specified items of information. Virtually none of the information required by the federal government to designate an authorized agent is contained on the organization's form, so it is uncertain whether the organization's authorization form will even be accepted by the NPDB.

- It is questionable whether entities that receive the additional explanations of adverse actions and malpractice claims from the organization will deem them to be credible, since they are not verified with the primary source,

i.e., the hospital that takes an adverse credentialing action.

- The federal government already provides an authorized dispute resolution process by which physicians can dispute the accuracy of information in a NPDB report. The NPDB encourages physicians to attempt to resolve the dispute with the reporting entity. If the dispute cannot be resolved, the physician can ask the Secretary of the Department of Health and Human Services to review the dispute. If the dispute is decided in favor of the physician, the original report will be voided. If the dispute is resolved against the physician, the physician can place a brief statement in the NPDB report describing the disagreement.

Recently, the Health Resources and Services Administration (HRSA) Bureau of Health Professions released its Interim Report to the NPDB Executive Committee. The report provides current information on topics of interest regarding the NPDB. The Bureau responded to requests for information about the organization (NDBRA) by stating: "The Bureau's assessment of NDBRA is that it appears to be a gimmick to identify high-risk physicians to sell them high-risk insurance".

Physicians who are interested in these types of services are urged to request that their attorney obtain information regarding confidentiality safeguards as well as any other information deemed necessary to protect the physician's interests.

*"The Bureau's assessment of NDBRA is that it appears to be a gimmick..."*

*For further information,  
contact  
Ilene Davidson Johnson,  
AMA Office of the  
General Counsel,  
(312) 464-4606.*

# Access to Food Constitutes a Human Right



World hunger is an ever-present scourge that claims 35,000 lives each day.

Access to food constitutes a human right. In 1976, the United States Congress passed a Right to Food Resolution which declared the sense of the congress to be "that all people have a right to a nutritionally adequate diet".

**Physicians Against World Hunger (PAWH)**, a non-profit, tax-exempt organization was founded so that physicians could collectively defend this human right by raising funds to support well-recognized, reputable organizations that are directly engaged in working with the poor primarily for the purpose of ending death by starvation.

Please join us—together physicians must help bring an end to world hunger.



**Physicians Against World Hunger**

#2 Stowe Road, Peekskill, NY 10566

YES I wish to join PAWH in the struggle to end world hunger — enclosed is my contribution.

☐ \$50    ☐ \$100    ☐ \$250    ☐ \$500    ☐ Other \_\_\_\_\_

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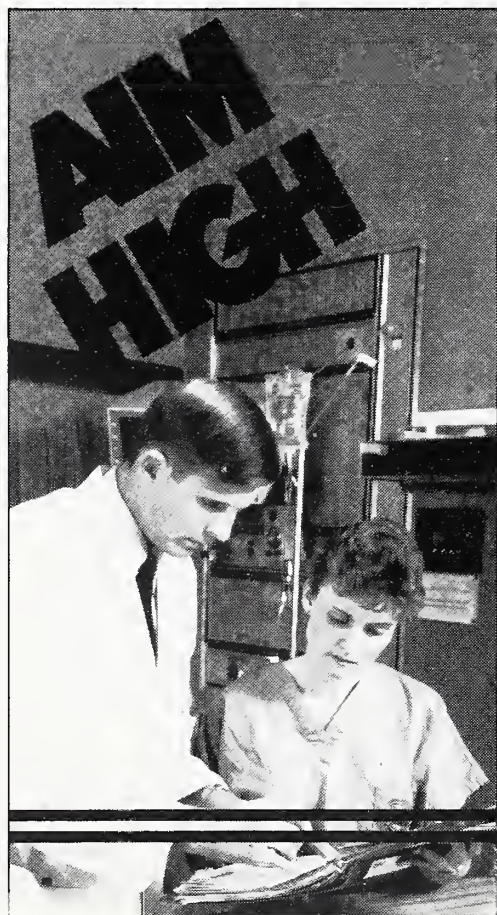
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STATE \_\_\_\_\_

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#2 Stowe Road, Peekskill, NY 10566



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# Pedioscopy: The Time Has Come

by **Roger C. Shenkel, M.D.**  
Family Physician  
Grand Junction, Colorado

In our small community we have struggled with reimbursement reform among our medical and surgical specialties. My impression is that we will never be able to get pediatricians to adequately charge for their services under our current fee systems. I would propose that we make a major shift in order to bring pediatrics up to par. I suggest pedioscopy.

Pedioscopy — here's how it would work. We construct a pedioscope — an apparatus that would be worn whenever examining children up to the age of eighteen. Training in the use of the pedioscope will become part of every pediatric residency. This new scope must be expensive, about \$6,000.00, and it will need to have both a highly technical light source and variable magnification. Repairs must be hard to arrange and expensive.

Evaluation and management of children will now become a procedure. As with all procedures, pedioscopy will have to be in the back of the CPT code book. The billing code will begin with a golden "8" instead of the more mundane "9". The mystique around our new instrument will require a slight fee increase. If a 15-minute office visit with a child goes for \$35.00, I would set a 15-minute visit with the pedioscope at about \$140.00 (extra training, more liability, more overhead — you have all heard the rationale).

How can a pediatrician afford a \$6,000.00 pedioscope, all the expenses of a procedure room and the staff to clean it? No problem. We arrange a 99070 supply code that allows him or her to buy a new scope every year — even though the scope will last for three years.

How does pedioscopy solve any problems? Let me explain. Pediatricians now will be able to double their income while working four days a week and going home at 4:30 p.m. The specialty will instantly become more genteel, more relaxed.

Who will take over the load when pediatricians no longer need to work their 70-hour week? No problem. Magically, more residency slots will appear and fill rates will skyrocket. We will soon have pediatricians looking for places to practice.

How will the public benefit? It may not be evident now, but soon we will know. The companies that manufacture pedioscopes will generously fund research projects to identify the amazing benefits of the new technology. We will be seeing things on kids that have never been seen before and will keep the news media in awe. "P" values will plummet.

How to convince the academia? Please re-read the last paragraph and remember who will be doing the research.

There will be some disadvantages. First of all, family physicians may start attending pedioscopy seminars and decide that they, too, should be able to perform and bill for pedioscopy. There may be some negative repercussions from the government. H.C.F.A. will likely initiate unfavorable press on a national scale. But the biggest risk may be the financial trap of too much time and too much income. Pediatricians may even begin to believe they can invest their funds well. If history repeats itself, they may end up in worse financial shape than they are in today.

But regardless, the time has come to give pedioscopy a try.

*A family physician in Grand Junction, Colorado, who got his tongue stuck in his cheek while struggling with reimbursement reform as president of a 140-physician multi-specialty IPA.*

# The Interview

A short story

(Part I of three parts)

*Whether 'tis nobler in the mind to suffer  
The slings and arrows of outrageous fortune,  
Or to take arms against a sea of troubles,  
And by opposing end them? To die; to sleep...*

— Shakespeare

## Alex Bookman

had a difficult time choosing a medical specialty. Like many students, his interests ebbed and flowed depending on the clinical rotation he found himself in at the moment. As the deadline for his residency

applications approached, he was perplexed. All he knew for sure was that he did not want to be an OB/GYN, owing to some experiences in which he became woozy and had to be assisted from the examining room.

In trying to sort through the various mailings, advice from friends, and other well-meaning counseling, Alex ran across a brochure from an obscure California program that offered the nation's first residency in thanatology. Not really knowing what thanatology was, other than the vague description that he read in the brochure, Alex decided to take a chance. He slapped together a personal statement and just managed to have his application forwarded before the deadline.

Some weeks later, Alex was invited for an interview. He made the necessary arrangements, borrowed his brother's brown suit, and boarded a plane for California. Upon touching down in the seasonless desert, Alex rented a car and set off to meet Dr. Erno Zyklon, founder and director of the thanatology program at Mercy Hospital.

Alex pulled into the parking lot just outside the Lucrezia Borgia Pavilion where the "Compassion Sciences" program was headquartered. As Alex sought a suitable parking space, the

car radio delivered some arcane advice from David Bowie: "...Run for the shadows/Run for the shadows in these golden years."

The grounds of the hospital were pleasant, not unlike those of most branch banks. The main walkway into the building was lined with saplings, all carefully staked so that they would grow properly and not be an embarrassment to the hospital. Off in the corner of the parking lot, Alex noticed a lone demonstrator propped up against a trash can, asleep. Against her chest she held a hand-lettered cardboard sign, the substance of which Alex recognized as being from Dylan Thomas:

*Do not go gentle into that good  
night  
Old age should burn and rave at  
the close of the day  
Rage, rage against the dying of  
the light.*

Alex continued through the automatic doors into the spacious lobby of the pavilion, his shoes slipping on the carpet. He noticed that his palms were a little sweaty as he boarded the elevator, rechecked the room number on his letter of invitation, and pressed the button for the third floor. The elevator intercom played the soothing strains from M\*A\*S\*H, "Suicide is Painless."

As the elevator doors opened, Alex stepped into the reception area, which he thought was a bit impersonal, with glaring white lights, like in a Stanley Kubrick movie. There were plastic trees in pots in the corners, and on the wall, a poster of the roadrunner being chased by Wile E. Coyote, except that the cartoon predator was wearing a stethoscope and carrying a syringe. Alex didn't bother to read the caption.



by **Joe Batuello, MSI**  
Denver, Colorado

After a few minutes Dr. Zyklon emerged and offered his hand to Alex. Alex thought Dr. Zyklon looked somewhat familiar, and after a few moments it occurred to him that the doctor bore a vague resemblance to Grandpa Munster, except that he wore green plaid pants, a white belt and white shoes.

Alex was led into Dr. Zyklon's office where he was introduced to a rather scary looking fellow named Vinny Carlucci, one of the directors of the program. The man was introduced as "mister" rather than "doctor" so it was assumed that he was not a physician. As he sat down, Alex wondered if Mr. Carlucci was the last man to see Jimmy Hoffa alive.

Dr. Zyklon launched into an enthusiastic description of the program. "This is the specialty of the future, Bookman. Think of it: thousands of terminally ill patients facing a life of what? Pain, machines and Medicare!"

The doctor suddenly became dramatic. "We offer an alternative, the right alternative,...the compassionate alternative."

Alex noticed Mr. Carlucci leaning back in his chair, cracking his knuckles. Dr. Zyklon continued: "Face it, Bookman, death is messy, it's unpleasant, and it's downright inconvenient. We allow people to choose how and when it's time to go, when the time is right for them. This way they can work around major holidays, school vacations and things of that nature. We're innovative, committed," Dr. Zyklon continued, patting Mr. Carlucci on the shoulder, "and experienced." Any questions?"

(Continued in **Part II, December, 1992**)

**Legal Representation before the  
Colorado State Board of  
Medical Examiners**

Jeffrey M. Laski  
Attorney at Law  
337-1400

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Edie K. Register, Director  
Health Care Financing

## Proper Use of Modifier -25

Grant Steffen, MD  
Medical Director, Medicare Part B  
Colorado Medicare Carrier

*"The recommendation here is 'Document—Document—Document'".*

Many physicians send me copies of claims that were denied by Medicare and that the physicians believe should have been paid. For the most part, I agree with their belief and then try to figure out why the claims were denied. On occasion the fault lies with the "System" here at the carrier's office (By the way, we deal with close to 400,000 claims per month.) I have found, however, that the majority of the time, the claim was the problem and many times, the problem was a failure to use modifier -25.

The AMA, through its CPT manual, developed modifier -25 as part of the new set of visit or evaluation/management codes. This modifier is used to identify a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure" (CPT, p. 564). Please note two aspects of this definition. First, the modifier identifies an E/M code and therefore should be appended *to that code* and not the code for the procedure.

Second, the CPT manual identifies both services and procedures.

The E/M codes are obviously identifying services. Most of the other 90000 codes (Medicine) and almost all of the surgical codes (10000-69999) identify procedures. In the Medicine section, the introductory paragraphs to the families of codes identifies them as either services or procedures. Anesthesia codes 00100 to 01999, identify services. Radiology codes, 70010 to 79999, identify both services and procedures. Laboratory codes, 80002 to 89399, identify services.

If you do a procedure and on the same day perform a significant separately identifiable evaluation and management service, you must attach -25 to the E/M code. If you don't, Medicare's system will not recognize that service as separately payable. Please review the definition of this modifier and all the modifiers that pertain to your specialty. These definitions make up Appendix A in the CPT manual.

You should also know that HCFA will ask the carrier to monitor the use of -25 on a post-payment basis. The recommendation here is "Document—Document—Document".



# El Paso County: Breaking the Chain

by Ken Gerhart, MA  
and Renée Johnson, BS  
*Spinal Cord Injury Early Notification System*

People with mild spinal cord injuries, including those who "walk out of the hospital", still face a chain of significant health and psychosocial problems. One Colorado county recently took steps to break that chain.

Individuals with incomplete and resolving spinal cord injuries may not have access to the benefits, interventions, and resources offered their more severely disabled counterparts who participate in rehabilitation programs. As a result, El Paso County, using disability prevention funds provided to the Colorado Department of Health by the U.S. Centers for Disease Control, developed a pilot program aimed at these particular spinal cord injury survivors.

Patients wishing to participate in the program were referred to El Paso County's public health nurses. All received in-home visits and comprehensive needs assessments.

The nurses helped these spinal cord injury survivors identify bowel, bladder, and skin problems; adjustment, financial and employment problems; depression; and alcohol and drug problems. They provided health and medical education, made referrals to vocational rehabilitation and drug treatment programs, helped individuals learn about entitlements and benefits, and helped initiate

necessary return visits to physicians.

Prior to beginning their pilot program, the public health nurses participated in an instructional program offered by the **Spinal Cord Injury Early Notification System (ENS)** in the Colorado Health Department. The ENS discussed spinal cord injury complications, identified local resources, and described problem-solving techniques. Even though the nurses were not specifically experienced in spinal cord injury management, they quickly became adept in assessing clients, identifying needs, and making the necessary referrals—all on the survivors' own home turf.

Although the initial seed money which got this program operational has been used, El Paso County continues to offer similar support to newly-injured residents. Other counties interested in this program should contact the ENS. Support can be offered in the form of technical assistance, training, and help in identifying patients and local resources. Also, El Paso county's nurses are willing to share their experiences and insights.

*For more information about the ENS, contact Renee Johnson at the Colorado Department of Health, at (303) 692-2637.*

---

*"Individuals with incomplete and resolving spinal cord injuries may not have access"*

# New home for the Colorado Department of Health



All of the Department's health and environmental program offices in the Denver Area (except the laboratory) have moved from four locations to one new headquarters at 4300 Cherry Creek Drive South.

The Laboratory Division remains at the East 11th address. Listed below are general information numbers for all divisions. Please use this as an update to page 234 of your 1992 *Medical Office Resource Book*.

## **New main Department Address:**

4300 Cherry Creek Drive South

Denver, CO 80222-1530

Main switchboard: (303) 692-2000

## **Program**

Administrative Services Division

Administration & Support

Air Pollution Control Commission

Air Pollution Control Division

Alcohol & Drug Abuse Division

Consumer Protection Division

Disease Control & Env. Epidemiology Division

Emergency Medical Services Division

## **Emergency response Line (environmental emergencies)**

Environment, Office of

Executive Director, Office of

External Affairs, Office of

Family & Community Health Services Division

Hazardous Materials & Waste Mgmt. Division

Health Facilities Division

Health, Office of

Health Statistics & Vital Records Division

Laboratory Division

Prevention Programs Division

Public Relations

Radiation Control Division

Water Quality Control Commission

Water Quality Control Division

## **Laboratory Division Address:**

4210 E. 11th Ave

Denver, CO 80220-3716

General number (303) 691-4700

## **Number**

692-2100

692-2100

692-3180

692-3100

692-2930

692-3620

692-2700

692-2980

**756-4455**

692-3000

692-2100

692-2020

692-2310

692-3300

692-2800

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Contact: Copic Risk Management Department, 779-0044/1-800-421-1834.

**Location:** CMS/Copic Offices, 7800 E. Dorado Place, Greenwood Plaza

Thursday, November 12, 1992  
Wednesday, December 9, 1992  
Wednesday, January 13, 1993  
Wednesday, February 3, 1993  
Tuesday, March 2, 1993  
Saturday, March 27, 1993

Wednesday, April 7, 1993  
Wednesday, May 5, 1993  
Wednesday, June 2, 1993  
Tuesday, July 13, 1993  
Wednesday, August 11, 1993

Faculty: Kenneth A. Kahn, M.D./Frederic W. Platt, M.D., for CMS.

Kathy Gardner, BSN, MA/Margaret Cary, M.D., (B.M.E.) for Copic.

Four credit hours Category 1 Continuing Medical Education. One Copic EN Point for Preferred Risk Premium Plan.

\* The coalition includes the Colorado Foundation for Medical Care, Colorado Medical Society, Colorado Personalized Education for Physicians, Colorado Physician Health Program, Colorado Society of Osteopathic Medicine, Colorado State Board of Medical Examiners & Copic Insurance Co.



### Over two million dollars given to Colorado EMS services.

Many communities in Colorado are in need of improvement to existing funding provided to Emergency Medical Services. Funds for these grants come from the \$1.00 surcharge on all motor vehicle registrations. The General Assembly passed the original legislation in 1989 and renewed it for another five years in the 1992 session.

This program provides upgrades in medical equipment, vehicles, communications and training for EMS providers. In the past, rural communities have been the most deficient in the area of emergency medical services. Two years ago when this program began, Colorado was ranked 38th in the nation for funding of EMS. This year Colorado ranks 16th.

The Colorado Department of Health's Emergency Medical Services (EMS) Division awarded the funds to 123 agencies. Over the next several months EMS providers throughout the state will receive \$2.5 million in grants to help improve their services for Colorado citizens and visitors.

"Again this year, special emphasis is being given to agencies that service the gambling areas," says

Larry McNatt, director of the EMS Division in the Colorado Department of Health. "With the extra traffic going to Cripple Creek, Black Hawk and Central City, this year funds have been awarded to Northeast Teller County Fire Protection District for an emergency vehicle; and to Golden Volunteer Fire Department, which services Highway 6, an access road to Blackhawk and Central City, for an emergency vehicle."

In the past two years over \$400,000 has been given to the services in the gambling areas.

With the introduction of limited gambling in the state of Colorado and the projected influx of visitors and income to the state these funds are a welcome addition to the safety and well being of our citizens and visitors.

### Scholarships Available to Needy Physicians

Applications are currently being accepted for three scholarships worth more than \$4,500 each for physicians to attend management education programs offered by The American College of Physician Executives. The annual awards are provided to physicians who are employed in health care organizations that provide service in areas that are medically underserved or

that rely predominantly on public or charitable funding.

Each scholarship includes tuition and a per diem for expenses for attendance at the College's national conference, May 11-15, 1993 in New Orleans, LA. The purpose of the scholarship program is to promote management development and training within organizations that do not typically have funds for this purpose available for their physician managers.

Deadline for submission is December 31, 1992. All submissions must be sent to:

Ms. Remie Cannon  
Scholarship Staff Coordinator  
The American College of  
Physician Executives  
4890 West Kennedy Blvd.  
Ste 200

Tampa, Florida 33609-2575

Applicants who need further information for clarification may call Remie Cannon at 1-800-562-8088

### These Diseases No Longer Reportable

During the September meeting of the Colorado Board of Health, the board approved the deletion of work-related asthma and work-related hypersensitivity pneumonitis from the list of diseases reportable by physicians and other health care providers.





## BOULDER COUNTY MEDICAL SOCIETY

Joanne M Edney, MD  
13555 Fitzsimons Way  
Aurora, CO 80011  
Elected 09/29/89

## EL PASO COUNTY MEDICAL SOCIETY

Patrick C Dunster, MD  
PO Box 460  
Woodland Park, CO 80866  
Elected 09/09/92

Joel J Kellner, MD  
311 N Union Blvd  
Colorado Springs, CO 80909  
Elected 09/09/92

Mark Krautheim, MD  
2301 E Pikes Peak Ave #201  
Colorado Springs, CO 80909  
Elected 09/09/92

Timothy S Rummel, MD  
1725 E Boulder St #204  
Colorado Springs, CO 80909  
Elected 09/09/92

## Physician Recognition Awards

Shari J Fitzgerald  
Curt R Freed  
Rebecca A Fried  
Robert A Fried  
Richard H Glasser  
Mark L Helm  
Enno F Heuscher  
Linton S Holsenbeck  
Daniel P Maher  
Lawrence R Menconi  
John R Mrozek  
Mark R Olson  
Ulysses S G Peoples  
Marion L Schmucker  
William R Seybold  
Patrick L Thompson  
Robert C Wright  
Paul C Zwiebel

## In Memory

Dr. Joseph H. Patterson of Englewood, died September 23 at the age of 81. Dr. Patterson was born in Denver. He graduated from the University of Colorado, Boulder, and the University of Colorado School of Medicine, Denver, in 1935. He completed his urology residency at Los Angeles County Hospital in 1942. he was a member of the Colorado Medical Society, Denver Medical Society, American Urology Association and the Denver Medical Club.

Dr. Patterson received his 50 year service award from the Denver Medical Society in September 1985. He is survived by his wife, Jean; two daughters, Beth Davis of Williamstown, Massachusetts, and Ruth Van Fleet of Edwards, Colorado; a son, Dr. James Patterson, an ophthalmologist in Denver; and eight grandchildren.

## RISK MANAGEMENT - SAFEGUARDING THE FUTURE

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For more information or a full brochure, contact MSMS Risk Management at (517) 336-5757.



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## RUMINATIONS

(def: to chew again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**  
Managing Editor

### A 'single-payer system'

Dr. Daniel "Stormy" Johnson, the Speaker of the House of Delegates to the American Medical Association, addressing the Colorado Medical Society Leadership Conference held in Grand Junction, July 12, 1992:



*"You don't have to go to Canada to understand what's wrong with a 'single-payer system'. You don't have to go out of this country or even this state. Maybe I'm wrong... maybe the Medicaid program in Colorado is fabulous. If it is, you're the only state that it's fabulous., but the Medicaid model is precisely the Canadian model. They're identical, and if you can imagine extending Medicaid to the entire population — Medicaid is a single-payer system; it*

*is a financial model of a single-payer system, and if you extended it to the whole population you would have the Canadian system. You don't have to bash Canadians, you don't have to criticize Canadian doctors or Canadian citizens or anything to understand what the shortcomings are. That program works very well from a variety of perspectives, and the most important one is it's simple."*

## Colorado Gynecological and Obstetrical Society



### Teen Pregnancy Prevention

The Teen Health Committee is continuing the "One Moment Can Change Your Life" poster campaign sponsored by the Denver Advertising Federation and Wyeth-Ayerst Laboratories.

### Membership Meeting

Philip Mead, MD, University of Vermont, headlined the November membership meeting at the Denver Marriott with his talk "Controversies in Managing Volvovaginitis".

### Joint Meeting with March of Dimes

As part of the Teen Health Education Committee's Teen Pregnancy

Prevention Project, over a hundred people symposium held with the March of Dimes on September 22. The purpose of "Talking with Teens About Sexuality: How to Make the Connection" was to train speakers for the teen pregnancy prevention program.



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To fax your request — (202) 638-0773





# COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

er, 1992

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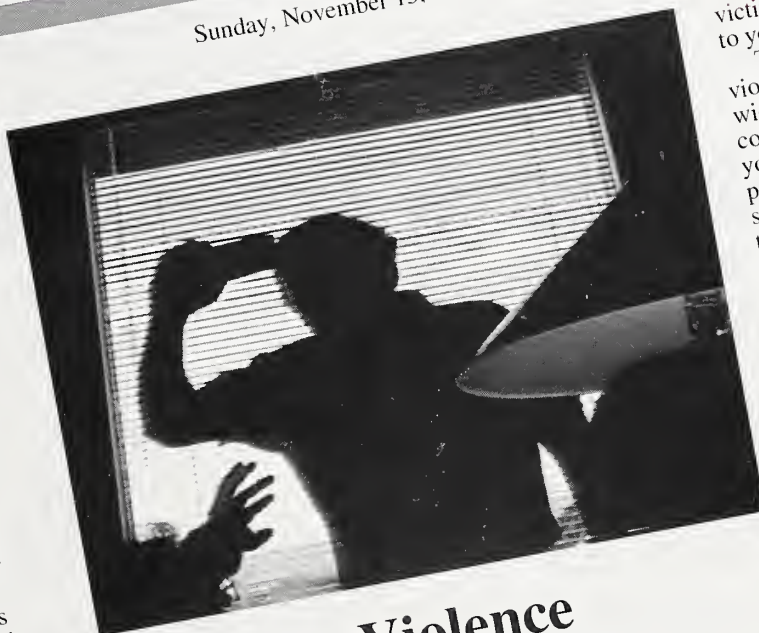
JAN 13 1993

Colorado T

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NOT IN CIRC.

Sunday, November 15, 1992



## Domestic Violence Continues to Increase

violence. Your patients' bruises, fractures and other injuries are often symptoms

victim of abuse in a letter to you, her trusted doctor.

The epidemic of family violence in America is widespread, deadly and complex. Even the very young, the very old and pregnant women may be safer on the streets than in their own homes, according to a recent article in the American Medical News. The cost to our society is staggering. And you, as physicians, are on the front lines, daily confronting effects of this national crisis.

Approximately every third patient you see is a victim of family violence. Your patients' bruises, fractures and other injuries are often symptoms of more sinister diseases. Your patient needs your help, doctors, you're being asked to treat not just the symptoms but also the underlying cause below the surface illness beneath.

is Issue:

Colorado Medical Society focuses on family violence and how the medical professional is involved:

A letter to my Doctor .....	Cherie Kirschbaum, R.N.
Domestic violence requires community response .....	Colorado Dep't. of Health
Copic: In line for a corporate takeover? .....	Conclusions of Copic and CMS leadership get-together
Medicaid miracle in Mesa County .....	Roger C. Shenkel, M.D.
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# COLORADO MEDICINE

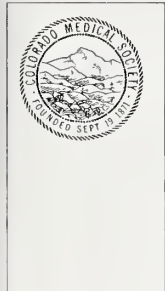
December, 1992

Volume 89, Number 12



## Cover Story

The best prescription for the grievous illness of domestic violence is public awareness. Health care professionals must be fully informed. CMS brings you a number of perspectives.



## DEPARTMENTS

- 427 President's Letter
- 429 Executive Director's Update
- 447 Health Care Financing
- 452 The Lobby
- 454 Committee Update
- 464 Ruminations
- 465 Classified Advertising

## In This Issue...

- 427 **Health Care Reform**—in the new administration  
*Leigh Truitt, M.D., President  
Colorado Medical Society*
- 430 **Family Violence: A letter to my doctor**  
*Cherie Kirschbaum, R.N.*
- 434 **Domestic violence requires concerted community response**  
*Deborah Haack,  
Family Violence Prevention Coordinator  
and  
Jackie Starr-Bocian, Public Information  
Colorado Department of Health*
- 437 **Domestic violence: Do you know...?**  
*A family violence awareness quiz for physicians*
- 438 **In the age of corporate takeovers, what about Copic?**  
*by the leadership of Copic Insurance  
and  
Colorado Medical Society,  
with the editor of "Copic Topics" newsletter*
- 440 **The physician in the year 2000—Conclusion**  
*Carol A. Walker, El Paso County Medical Society*
- 443 **The Interview—Part II**  
*Joe Batuello, MSI*
- 444 **Medicaid miracle in Mesa County**  
*Roger C. Shenkel, M.D.*
- 446 **\$3 million to improve rural health services**  
*Lindy Nelson, Colorado Dep't of Health  
and  
Peg O'Keefe, Vice President, Colorado Hospital Assn.*
- 448 **OSHA Update**  
*Bonita Carson, M.D.*
- 449 **The life and times of a locum tenens**  
*Richard F. Bedell, M.D.*
- 457 **Mile High News**  
*CMS Auxiliary*



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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor



Member, Colorado Press Association,



Member, Colorado Broadcasters Association





Leigh Truitt, MD  
President, 1992-1993

## Health care reform in the new administration

**The election is over.** The dust has settled. We have chosen a president, elected a congress, and filled many state offices. What happens now? In the words of President-Elect Bill Clinton:

### Overall structure to contain costs and ensure access

"We will establish a National Health Board composed of consumers, providers, and representatives of business, labor, and government. That board will establish annual budget targets and define a core benefit package that must be available to every American. Benefits will be provided by employers and public programs through a reformed insurance system and the use of collaborative health care networks that serve those in both private and public plans. The networks and other insurers will offer health care within the global budgets. States may establish consistent rates applying to all payers for services provided outside managed-care networks as a backup mechanism to meet the global budget targets. An intensified health education program will strive to persuade Americans to change unhealthy, and costly, personal behavior.

### Core benefit package

The board will establish national and state budget targets for health care to guide expenditures in the public and private sectors. It will also establish a core benefit package for private and public plans that will

include ambulatory care, inpatient hospital care, prescription drugs, basic mental health care, and important preventive benefits such as prenatal care and screening mammography.<sup>1</sup>

**Think about this:** a universal, top-down, "national government knows best" approach for all of health care. Even after watching the state planned economies of the Soviet Union and Eastern Europe topple, we have advocates of this sort of system in the United States.

At a recent meeting of the Colorado Health Forum, the CEO of an HMO stated that health care providers must move from a revenue driven approach in providing health care to a cost control strategy. This is only true in part. We really need to improve outcomes, to obtain better results for our patients — and lower cost is only one of the many better outcomes we should be seeking.

**Outcomes research** is in its infancy. How often are we sure which of several therapeutic strategies will lead to what we ourselves regard as an optimum result? When do we know if that result also meets the patient's expectations? I fear that we will see a cost-oriented, protocol-dominated approach to medical care — a top-down, financially driven control system driven by expert opinion rather than outcomes research. We may face a benefit structure and resource allocation that will further distort and impair our ability to provide better outcomes.

There exists a different approach to management empowerment of those actually providing care.

In the words of H. Thomas Johnson: "With just-in-time strategies, learning and choice become part of daily work, not the exclusive domain of planners at the top. Planning and innovation become synonymous with real-time operations. Operations become strategic. Strategy, instead of being defined by top-down concerns with financial results, is defined by bottom-up concern with improving processes that satisfy customers' expectations and fulfill workers' potentials."<sup>2</sup>

You are invited to attend our one-day seminar, **Continuous Quality Improvement: A Tool Physicians and Hospitals Can Use Together to Manage Change.** On January 15, 1993, at the Hyatt Regency Tech Center, you will hear how a bottom-up approach to quality and cost issues is solving problems at three hospitals in Colorado: St. Mary's in Grand Junction, Parkview in Pueblo, and Penrose in Colorado Springs. I look forward to seeing you there.

<sup>1</sup> Governor Bill Clinton, "The Clinton Health Plan," *The New England Journal of Medicine*, 327:804-807.

<sup>2</sup> H. Thomas Johnson, *Relevance Regained From Top-down Control to Bottom up Empowerment*, (New York: The Free Press, 1992), p. 200 (emphasis in original).



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# CMS Med Fax<sup>®</sup>

**AT PRESS TIME...**

a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

CMS Med Fax<sup>®</sup>

by *Montgomery Little Young Campbell and McGrew, P.C.*

legal counsel to the Colorado Medical Society

## November 11—"48 Hours" focuses on "unique Colorado program"

### CPEP provides more details

Dear Colleague:

For those of you who may have watched the television show "Bad Medicine" on 48 HOURS, Wednesday evening, November 11 you may have heard about a program in Colorado working with physicians for retraining of their clinical and interpersonal skills. The last segment of the 48 HOURS program entitled "Heal Thyself" with correspondent Regina Blakely featured a unique program developed in Colorado through the efforts of seven major healthcare organizations. The television show did not mention the correct name of the physician education program. It also focused on Denver General Hospital and made it appear as though the program was based in that facility. If you are interested in finding out further information about the program, the name of the program is Colorado Personalized education for Physicians (CPEP). For further information on CPEP and how you may utilize its services, please contact the organization as follows:

Roxanna Lynn Fredrickson

Executive Director

Colorado Personalized Education for Physicians (CPEP)

5575 DTC Parkway, Suite 350-A

Englewood, CO 80111

Phone: 303-773-0440 Fax 303-796-0334

Your attention to relaying this information to other colleagues would be appreciated.

## New Disability Journal Created

Richard L. Stieg, M.D. has recently been named Editor-In-Chief of *The Journal of Disability*, the scientific publication of the American Academy of Disability Evaluating Physicians (AADEP).

The Journal will contain the latest medical, legal, and regulatory information related to the disabled, written by health care and rehabilitation professionals, with information related to the disabled, written by health

care and rehabilitation professionals, with information also provided by advocates and public advisors for the disabled.

"Until now," Dr. Stieg stated, "there has been no single educational resource available to serve the comprehensive needs of the disabled and for those who provide support and intervention for the disabled. Given the Incentive for action of the new Americans with Disabilities Act (ADA), we anticipate that *The Journal of Disability* will have widespread readership interest, and

*continued on following page...*

## New Journal

*from page 1*

is expected to grow rapidly and change in scope according to the needs of its readers."

First publication of *The Journal of Disability* with Dr. Stieg as Editor-in-Chief is scheduled for March 1993. Dr. Stieg, a board-certified neurologist, is well-recognized as an authority on chronic pain and disability. He currently serves as the Executive Medical Director at Colorado Rehabilitation Institute and as the Medical Director of The Head Pain and Neurological Center, a component of Colorado Rehabilitation Institute. Colorado Rehabilitation Institute is an affiliate of Swedish/Spalding Hospital Systems in Denver, Colorado. Dr. Stieg is also founder and Medical Director of Medical Case Management, Inc., in Denver which is a physician-directed organization of health care professionals providing case reviews, second medical opinions, and independent medical evaluations for legal firms and payors of health care services.

For more information contact the Colorado Rehabilitation Institute at (303) 451-7700.

## Motorcycle Death Study

A University of Maryland study followed 933 motorcycle drivers who were transported from the scene of a police-reported crash: 50 died, 377 were admitted to a hospital, 15 left against medical advice, and 491 were treated and released. Unhelmeted drivers were twice as likely to have sustained head injury and much more likely to require hospitalization. Acute care cost for unhelmeted drivers were twice as likely to have sustained head injury and much more likely to require hospitalization. Acute care cost for unhelmeted drivers was three times that of helmeted drivers. Drivers that did not wear helmets were also more frequently involved in high risk behavior. *Accident Analysis and Prevention*, (Vol. 24, No.4) Aug. 1992.

Reprinted from, Network News, a bi-monthly publication of the Colorado Department of Health, Injury Prevention Program.

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

### Lutheran Medical Center and Alzheimer's Association

"Preparing for the Future: Legal and Financial Concerns and Community Resources"

Monday, November 16, 1992

Speaker: Marola Reish, B.S.N.

Program Associate, Alzheimer's Assoc., Metro Denver Chapter

1-3pm

Helen Matthews (303) 425-2094

### Porter Memorial Hospital Foundation

1992 Heart of Hearts Gala XII

Hyatt Regency Tech Center

Englewood Co

November 21, 1992

(303) 761-0186

### Medical Education Resources

Advances in Vascular Diseases

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

### Medical Education Resources

Asthma and Allergy in the 1990s

Orlando FL

November 20-21, 1992

(303) 798-9682 or 1-800-421-3756

### Radiological Society of North America

78th Scientific Assembly & Annual Meeting

Chicago, IL

November 27 - December 4, 1992

(708) 571-2670

### Colorado Department of Health

Hispanic Health Issues Conference

December 4&5, 1992

Sheraton Hotel

Colorado Springs, CO

Deadline for registration is November 16, 1992

(LARASA) (303) 839-8300

### Prosper Meniere Society

Diagnostic & Rehabilitative Aspects of Balance & Movement Disorders

December 2-6, 1992

Denver, CO

Jane Wells (303) 788-4230

### American Medical Association Hospital Medical Staff Section Twentieth Assembly Meeting

December 3-7, 1992 Opryland Hotel

Nashville, Tennessee

(312) 464-4754 or 464-4761





# COLORADO MEDICINE

## Cumulative Index

## Volume 89, 1992

### Official Journal of the Colorado Medical Society

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- 9 HEALTH FAIR, 58**  
*58th General Assembly of the State of Colorado*, (Second Session), after p. 14  
*1992 Colorado Health Professions Loan Repayment Program*, 15  
*1992 Colorado Medical Society Leadership Conference*, (Truitt), 302, 303  
*1993 INTRAV Trips Announced*, March Med Fax  
*Abraham Lincoln: Malpractice Defense Attorney*, (Lewis), 279  
*Additional Changes to Immunization Requirements*, (Livingston), 264, 265  
*AIDS Debate Continues*, March Med Fax  
*Alert!*, August Med Fax  
*Ambassadors of Science*, (Maestas), 362  
*Amendment 1 Alert!*, October Med Fax  
*Americans With Disabilities Act: may require changes for your practice*, (Larkin), 78, 79  
*Americans With Disabilities Act: Steps Toward Compliance*, (Burns), 270, 271, 272  
*Americans with Disabilities Act Resource Directory Information and Resources*, 273  
*Americans with Disabilities Act Update, How to comply*, (Karlín), 320, 321  
*An Open Letter to Colorado Physicians*, (Dickey), 233  
*Antitrust Action*, (Best), July Med Fax  
*Arbitration: Not necessarily the Answer*, (Best), October Med Fax  
*Are You Current With Current Procedural Terminology?*, 92  
*Are Your Workers Vaccinated?* September Med Fax  
*Attend Your Precinct Caucus on April 14*, April Med Fax  
*Autonomous Medical Treatment Decisions*, (Best), 222, 223, 224, 225  
*Better Communication*, (Thompson), 372, 373  
*Bloodborne Pathogens: The \$821 Million Standard*, (Treber), 158, 159  
**BOARD HIGHLIGHTS, 94, 281**  
*Breast Cancer Screening, Results and Follow-up for Colorado Women*, (Chrvala, Todd, Math, Hurlburt, Nadel), 179, 180, 181  
**CARING ABOUT HEALTH CARE**, (Levine), 114, 115  
*CDC Issues New Immunization Consent Forms*, 87  
*Certified Correctional Health Professionals*, (Chavez), 75  
*Claims to be denied for failure to include Unique Physician Identification Number (UPIN)*, May Med Fax  
**CLASSIFIED ADVERTISING, 25, 26, 64, 66, 101, 102, 141, 142, 194, 195, 291, 292, 293, 330, 331, 379, 380**  
*CMS Promotes Tobacco Free Schools*, March Med Fax  
**COLORADO DEPARTMENT OF HEALTH, 16, 17, 18, 62, 63, 86, 126, 127, 128, 179, 180, 181, 260, 261, 322, 323, 324**  
*Colorado Gynecological and Obstetrical Society*, (Fox), 370  
*Colorado Health Care Reform, prepared By CMS Board of Directors, August 21, 1992*, 349, 350, 351, 352, 353  
**COMMITTEE UPDATE, 53, 54, 183, 228, 280**  
*Communicating Environmental Risk*, 322, 323, 324  
*Compac Wins!*, 269  
**COMPAC, 123**  
**COPIC COMMENT, 63, 283**  
*COPIC Decade 2, Report to the Membership of the CMS House of Delegates*, after p. 132  
*CPEP Wins National Award*, 57  
*Cramped and tongue-tied writers*, (Coloman), 377  
*Daniel Ellsberg to Keynote Conference*, August Med Fax  
*Dear Patient: Help me continue as your physician*, August Med Fax  
*Death Certificates-Fill them Out Carefully (and Correctly)*, (Stein), 19  
*Decade of the Child in Colorado*, (Colorado Children Campaign newsletter), 259, 260, 261  
*Delegate Attendance—1992 Annual Meeting*, 358, 359, 360  
*Denver Medical Library to Offer Online Information*, May Med Fax  
*DHHS Can Fix Prices*, (Best), July Med Fax  
*Doctors Day- 1992, 150 Years of Victory Over Pain*, 85  
*Domestic Violence Support*, (Platt), 13  
*Domestic Violence Training Guides For Health Care Providers*, October Med Fax  
*Dr. Selner—ACAI*, January Med Fax  
*Ehhicks and "Managed Health Care"*, (Pierson), 39, 40, 41, 42  
**EMS Physician Advisors: Duties and Responsibilities**, (Greisman), 161, 162, 163  
*Evaluation and Management Codes*, (Steffen), 368, 369  
**EXECUTIVE DIRECTOR'S REPORT (Maloney), 7, 111, 112, 151, 152, 215, 257, 301, 347**  
*Experimental Treatment?*, (Best) February Med Fax  
*Free Immunizations*, September, Med Fax  
*Good News for Health Promotion in Schools*, (Doster), 258  
*Governor Romer Sees 'Health Care Crisis'*, 34, 35  
*Have Some Influence*, January Med Fax  
*Hawaii: sandy beaches, tropical breezes and... "SHIP"*, (Maloney), 151, 152  
*HCFA Forces CFMC Cutbacks*, October Med Fax  
**HEALTH CARE FINANCING (Register), 129, 130, 131, 176, 177, 226, 227, 276, 277, 368, 369**  
*Health Care Policy for the 90's*, (Butler, Maloney), 43, 44, 45, 46, 47, 48, 49, 50  
*Health Care Reform, Questions for Patients, Physicians*



and Society, (Truitt), 339, 340, 341, 342, 343, 344, 345  
*Health Care Reform: Let's put control at the state level!*, (Butler), 211, 212  
*Highlights of the 1992 Annual Meeting*, 354, 355  
*Highlights of the Board of Directors Meeting, March 27, 1992*, 184  
*Highlights: Board of Director's Meeting September 10, 1992*, 371  
*HIV and Disability*, 87  
*Income & Expense*, (Best), July Med Fax  
 INSIDE CMS, 161, 162, 163, 164  
 INTERIM MEETING 1992, 133, 134, 135, 136, 137, 138  
*IRS Becomes More Liberal for Profit-Sharing Retirement Programs*, 317  
 JUNE—SPECIAL ISSUE: 1992 Annual Meeting  
*Legal Duties and Authority of the Health Department*, 12  
*Letter From The Editor*, (Moldauer), 132  
 LETTERS, 57, 80, 213, 214, 361  
 LOCUM TENENS, 56  
*Mammography Specialists*, January Med Fax  
 MEDICAL NEWS, 22, 23, 139, 192, 193, 229, 230, 246, 247, 248, 284, 285, 286, 329, 374, 375, 376  
*Medical Records*, (Best), May Med Fax  
*Medical Society Takes Physician Complaints to Insurance Commissioner*, (Hill), April Med Fax  
*Medical Training in Costa Rica*, (Maestas), 266, 267  
*Medicare Fee Schedule: The Good, the Bad and the Ugly*, (Painter), 172, 173, 174, 175  
*Medicare*, (Best), April Med Fax  
 MILE HIGH NEWS (Larkin), 95, 96, 97, 98  
*Mile High Transplant Bank Breaks Ground for New Facility*, September Med Fax  
*Mini-Internships: A Vital Role "Ambassadors of Medicine"*, (Maestas), 220, 221  
*More Doctor Bashing*, (Butler), 255, 256  
*More on E&M Codes*, (Steffen), 276, 277  
 NEW MEMBERS, 184, 185, 186, 187, 188, 189, 190, 191, 244, 245, 324, 325, 326, 327  
*New Health Chief to Speak at Interim Meeting*, February Med Fax  
*New Physicians Have Allies*, April Med Fax  
*Non-Physician Medical Care*, (Berg), 274, 275  
*Now, Bill; that is just plain silly!*, (Butler), 33  
*On Being A Doctor*, (Curtis), 8, 9  
*On The Campaign Trail*, (Elliff), 364  
*Oregon plan gets unplanned rejection*, (Best), October Med Fax  
 OSHA Information In The Mail, May Med Fax  
*OSHA Workplace Requirements In Effect: Direct Impact on Physician Offices*, 76, 77  
*PaperChase Now On Line*, September Med Fax  
*Parent-Professional Partnership in Fremont County*, (Mohr), 366, 367  
*Participate In 1992*, 234, 235, 236, 237, 238  
*Participation '92*, (Galloway, Brown), 363  
*Participation '92, Physician Participation is Critical*, (Galloway, Brown), 310, 311, 312, 313, 314, 315  
*Participation '92, Targeting 100% Voter Involvement*, (Galloway, Brown), 153, 154  
*Passing of Friends*, 59  
*Pharmacist with HIV*, (Best), July Med Fax  
*Physician Employers and the Americans With Disabilities Act: Are You Ready?*, (Treber), 242, 243  
*Physician Note*, April Med Fax  
*Physician Professional Marketing, A Personal Opinion*, (Burdick), 93  
*Physician Recognition Awards*, 60  
*Physicians Can be Employees of Medical Clinics*, (Best), April Med Fax  
*"Please... no more letters!"* (Butler), 5  
*Physicians To Face Lower Reimbursement*, July Med Fax  
*Policy on HIV Infected Physicians*, 10, 11, 12  
*Polio, Rubella, DPT, and now Hepatitis B shots*, (Best),

October Med Fax  
*Positive Progress on Rural Health Care*, 55  
*Practice Parameters, Insurance Companies and the Government*, (Butler), 73, 74  
*Prescription Drug Abuse: It Could Happen to Somebody's Mother*, (Dorr), 164  
*President Bush Addresses Health Care Priorities*, 36  
 PRESIDENT'S LETTER (Butler, Truitt), 5, 33, 73, 74, 109, 149, 211, 212, 255, 256, 299, 300, 339, 340, 341, 342, 343, 344, 345  
*Prevention of Low Birthweight Births by Reduction of Behavioral Risks During Pregnancy*, (McCurdy), 262  
*Proceedings of the House of Delegates*, 356, 357  
*Protecting Your Assets*, (Thompson), 160  
*Puerto Rico: Foreign or Domestic?*, (Best), July Med Fax  
*Questions Frequently Asked About CLIA*, (Donaldson), 240, 241  
*Rainer Honored at Alma Mater*, September Med Fax  
*Recoil*, (Pierson), 55  
*Robert Wood Johnson Foundation Approves Colorado Universal Health Care Study Grant*, August Med Fax  
 RUMINATIONS, (Pierson) 113, 196, 232, 287, 288, 289, 290, 332, 378  
*Rural Health Grants for Colorado*, 14  
*Rural Health: Caring for the country*, (Thompson), 117  
*"Rural Lifestyles" Helping Students Care About Health*, 118  
*Saddling A Cow?*, (Maloney), 111, 112  
 September: "Women In Medicine" Month, (Maestas), 304, 305, 306  
*Six and a Half Really Good Reasons to Blow Up the National Data Bank*, (reprint from Illinois Medicine), 178  
*Six Honest Servingmen*, (Treber), 318, 319  
*Smoke Free Dining Guide*, 316  
*Social Services Policy Upheld*, (Best), July Med Fax  
 SPECIALTIES, 21, 99, 140  
 STUDENT MEDICAL SOCIETY, 88  
*Sunscreen Q&A*, (Tegtmeier), 169, 170  
*Thanks Go To Physicians Who Served As Judges At Successful '92 Colorado State Science Fair*, 282  
*Thanks Go To Physicians Who Served As Special Judges at Successful '92 Colorado State Science Fair*, 365  
 THE LOBBY (Rapp, Quam, Koehn), 51, 52, 81, 82, 83, 84, 119, 120, 121, 122, 155, 156, 157, 308, 309  
*The ADA of 1990: Questions and Answers*, (Best), August Med Fax  
*The All-Payer Alternative: Controlling Costs Through Competition*, (Kroger), 216, 217  
*The Americans With Disabilities Act: Its Impact On Your Practice*, after p. 160  
*The Bag Lady*, (Hutchison), 88  
*The Class of 1992 and the CMS in the Year 2000*, (Nelson), 166, 167, 168  
*The Colorado Medical Society and Health Care Reform*, (Butler), 149  
*The More Things Change, the More They Stay the Same*, 37  
*Thermography: Like a Wart, It Keeps Coming Back*, (Best), October Med Fax  
*Time for the 1992 Directory*, 124  
*Tort Reform Damage Cap*, (Best) February Med Fax  
*Visit Codes and Dump Codes*, (Steffen), 176, 177  
*Wait! What is it We're Trying to Reform?*, (Farrington), 218, 219  
*What a Year!*, (Maloney), 301  
*Where Health Care Reform Will Take Medicine: the destructive larva syndrome or the gallows theory*, (Pierson), 287, 288, 289, 290  
*Who Are Your Patients?*, (Best) February Med Fax  
*Women in Medicine*, (Best), July Med Fax  
*Women's Health Issues 1992*, August Med Fax  
*Would you Do It, Doctor?*, (Coleman), 91, 92  
*"Your Right to Make Health Care Decisions"*, May Med Fax



## EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney  
Executive Director  
Colorado Medical Society

Dear Friends:

As I am writing this, we are busy preparing for the AMA Interim Meeting which starts on December 6th in Nashville. In scanning the Delegates Handbook, it appears that the meeting will be very interesting. Yes, there are some of the same old issues. However, it is my impression that a lot of time will be spent addressing the issue of health care reform and certainly, the election of Bill Clinton to the Presidency will be a topic of discussion.

The AMA must quickly position itself with the Clinton administration and be the national leader in advocating for physicians and their patients. Another hot topic at this meeting will be the ethics of self referral. It seems that the opinion of the AMA Council on Ethical and Judicial Affairs does not necessarily represent the views of AMA membership. Please look for a complete update on the actions taken at the AMA Interim Meeting in a future issue of *Colorado Medicine*.

Colorado will be well represented at this meeting as we have a full contingent of delegates and alternates attending. Doctors Quinn, Painter, Levine, Bogin, McCartney and Karlin do a fine job of representing Colorado physicians at the AMA meetings. Doctors Truitt and Bailey will also be attending. Of course, I will attend as Secretary of the Rocky Mountain States Conference and to make sure that the CMS Delegation doesn't get lost in Nashville!

Closer to home, the CMS Board met on November 20th. They decided to have the Interim Meeting

April 2-4, 1993, in Colorado Springs. They also voted to hold a separate Leadership Conference/Planning Session sometime in July.

We are hoping to convene the July meeting in Fort Collins. The Interim Meeting will be held just as then-President Clinton's first 100 days in office come to a close. We should have a tremendous number of topics for discussion. Doctor Bailey is busy working on what seems to be an exciting Planning Session. The highlights of the entire Board meeting will not appear until the January issue of ***Colorado Medicine***.

Speaking of the first 100 days, I wonder how Doctor Truitt feels as his first 100 days as President of CMS comes to an end? I can tell you that Leigh is sometimes radical and certainly brings his own opinions (most presidents do) to CMS; however, he has and will continue to do a fine job representing the views of CMS membership. I hope he feels good about his first trimester.

I can't believe this is the last magazine of 1992. Time goes by so quickly. We have covered a lot of ground this year, with perhaps more issues and problems to face with the coming year. Discouraged? Never! Challenge is what makes my job so exciting. And I am sure that 1993 will be no different.

My best wishes to you and your family for a very happy Holiday Season. May 1993 be healthy and prosperous!

Warmest regards.

Sandi

*The AMA, the first 100 days, and leadership*

# Family violence:

## A letter to my doctor

The epidemic of family violence in America is widespread, deadly and complex. Even the very young, the very old and pregnant women may be safer on the streets than in their own homes, according to a recent article in the AM News. The cost to our society is staggering. And you, as physicians, are on the front lines, daily confronting the effects of this national crisis.

Approximately every third patient you see is a victim of family violence. Your patients' bruises, fractures and other injuries are often symptoms of a far more sinister disease. The patient needs your help. As doctors, you are being asked to treat not just the symptoms but also the underlying cause—to look below the surface to the illness beneath. As healthcare professionals you are being asked to take the lead in helping society eradicate this devastating epidemic and restore the health of our families through these individual lives.

In a letter to you, her trusted doctor, the following profiles a victim of abuse.

by **Cherie Kirschbaum, R.N.**

*"I want you to take a few extra moments and help me to tell you the truth."*

Dear Doctor:

I am your patient, employee, neighbor, colleague, friend, sister, mother, daughter or wife. You see me everyday. I am a wife, mother, live-in partner or girlfriend, in a relationship where I have been called names, told I was no good and worthless, stupid and lazy. I have been pushed, shoved, slapped, punched, kicked, choked, tied up, beaten, stabbed or burned. I am blamed for things that are not my fault. I have been threatened, manipulated, warned and humiliated in public. I have been forced to have sex when I didn't want to—"No" wasn't enough. I have had a gun held to my head and a knife at my breasts. I have been forbidden to see my friends and family and have been told if I leave I will never see my children again. I turn my paycheck over immediately, never having money of my own. My most precious heirlooms have been smashed against walls and I have seen our family pets kicked and maimed. I am compared to other women and told I am too ugly, fat or thin. I am told how to dress and never to look at

another man. I have been forced to hear stories about his affairs or else told it is none of my damn business. I have watched my children get spanked and slapped after I have been beaten, too terrified to protect them. While pregnant, I was kicked in the stomach more than once and warned not to tell anyone, especially you.

I am white, black, Hispanic, Chinese or Arab. I am Catholic, Jewish, Christian, Muslim or atheist. I am 18, 40 or 65 years old. I am a college graduate or a high school drop-out. I live in the suburbs or the inner city. I earn over \$50,000 or am on welfare. I work in corporate America, or as a housewife. I am a professional, hold down two jobs or work not at all. I am a community leader volunteering my time and money. I go to church or synagogue, the theater, school activities, or I am the woman always missing. I wear the latest fashions, conservatively dressed or wear clothes from Goodwill. I change my hairdo and appearance frequently, trying to please. I am the woman who everyone admires, because I do so much for



**'... anyone who lives in a violent home experiences an essential loss. The one place on earth where they should feel safe and secure has become a place of danger... the shadow of domestic violence has fallen across their lives and they are forever changed.'**

*United States Attorney General's Task Force on Family Violence, September, 1984*

others or I never seem to accomplish anything. I am the woman too shy to speak, avoiding eye contact, or I flirt with other men to get attention.

My children are overachievers or struggle with school. They don't like adults very much and are scared or angry most of the time. You may think I am an overprotective Mom or that I neglect my kids. When I yell at my kids out of frustration, I feel worse. My husband or boyfriend threatens the kids or tells them their mom deserved what happened to her. He buys them presents to make up for what he did to me. I am held hostage by what he says about me, unable to call for help.

When I come to your office or see you in the Emergency Room, you don't always know the real me. I lie to you to protect myself and my kids, to hide the terror that I feel inside, to calm the trembling of my hands, feet or legs. Sometimes, I don't even know that what is happening to me is wrong. I think I deserve to be beaten. I have learned to believe what he says about me. After all, he is my husband and it is up to me to make the marriage work. I come in for recurring headaches, stomach aches, and other general complaints. The tests you run are always negative. You look so puzzled and then order more tests. I talk about being depressed and sometimes you order drugs to elevate my mood, but the drugs only make me feel worse, more helpless and crazy and often I will use them to attempt suicide.

I am sometimes timid and shy, reluctant to disrobe even after the nurse has handed me a gown. What you would see might reveal my

secret: bruises around my face, neck, arms, ribs and waist; burn marks under my breast and on the insides of my thighs; rope burns on my wrists and ankles and extreme weight loss or gain. I might be bulimic, anorexic or overweight, and complain that I can't eat anything or that all I do is eat. I complain of a sprained ankle from tripping down the stairs and tell you often how clumsy I am. I break bones more often than usual, especially ankles, wrists and ribs. I pull tendons in my thumbs and end up with a cast. I have literally bit my tongue after being hit in the face and sometimes crack a tooth "after eating hard candy." I "burn myself with the iron", I bang into doors, hit my chest on the steering wheel, trip over things and can't remember how some of my "accidents" happen. I have a hard time telling the same story twice, because the details are "fuzzy." I am embarrassed and ashamed and am in a hurry to get out of your office. I flinch when you try to touch me or show any kindness. I don't know how to ask for what I want and often I don't even know why I came to see you. Many times I cancel appointments at the last minute because I don't want you to see me looking this way. If you ask me about my family I might tell you, "we are all fine" and relate our latest travels or the gifts that I have received.

Often the only time you will see me is when I am pregnant and he has punched me in the belly. My partner may insist upon staying in

*"I have been pushed, shoved, slapped, punched, kicked, choked, tied up, beaten, stabbed or burned."*

*(Continued on following page)*

## C. R. S. Sec. 12-36-135 Physician Shall Report Criminal Acts

***Requires that any physician who attends or treats... any [other] injury which he has reason to believe involves a criminal act... shall report that a crime has been committed to the appropriate law enforcement agency.***

*"... you don't always know the real me. I lie to you to protect myself and my kids. To hide the terror that I feel inside..."*

the Emergency Room while you examine me, because he wants to make sure I don't tell the truth. Out of guilt and fear of losing the baby, he has allowed me to come to the hospital. Or he took my other kids and kept them at home, threatening he'd hurt them if I told you how my miscarriage really happened.

Sometimes I am in a single car accident, using my car to escape -the vehicle of my despair. I may seem hysterical, difficult, sullen or angry and enraged, ready to fight back. I have dark circles under my eyes or heavy make-up to cover them. I am unable to give you a straight answer and mumble my words. I don't always follow your instructions or I am most obedient, "the good and easy patient." My neediness makes you want not to help me and you notice yourself shaking your head, making comments to your nurse.

Yes, this is overwhelming. To you and to me. You may want to run... off to see the next patient you can help in the traditional ways you were taught to heal disease. You might say "I want to help, but I don't have time. My waiting room is full of patients". Or, you might think you know what family violence really is and simply ask me, "why don't you leave him?" You may feel that you told me what to do and I didn't do what you suggested, so why bother. You may not want to get involved with the legal, judicial and social service systems, so you turn the other cheek. Or, my husband or boyfriend might be your patient, friend colleague or a community leader and you have a hard time believing that the same man you know could do

this to me. And, you fear for your own safety if you get involved. Even if you want to help me, you feel timid to ask questions because you don't know what questions to ask. And if you do ask you might never see me again.

But I need you to ask. I hope you will ask. "Did someone do this to you?..." I want you to tell me that no one deserves to be hurt and beaten. I want you to take a few extra moments and help me to tell you the truth. I want you to look at me, even if I look away. I don't want you to look at me with pity or disdain. I want you to know that it isn't only you I don't trust, it is everyone. And I am in pain.

Please don't think that I am crazy for staying in the marriage. Leaving is not as easy as it seems. I want you to know that if and when I leave, I am in the most danger of all. I worry about how I will support myself, where my kids will go to school. Will they be hurt or kidnapped? Where will we go to be safe? It may take me several years to find the courage to leave. One visit in your office can plant the seed, but please understand I am fragile, frightened and overwhelmed. I need time to think about what you say. So, be honest with me. Tell me gently, but firmly that this behavior is against the law. Let me know that my injuries are not consistent with my stories and that my stories change every time you ask me questions. Inform me that you have a legal responsibility to report my physical injuries. I want you to ask me if I am taking drugs or if my husband is drinking more than usual. Ask me if my



**"Spouse abuse is not a private matter; it has ramifications beyond the immediate family."  
"Any solution to the problem of violence will require a total community effort in  
which health care providers can play a special role."**

*Surgeon General's Workshop on Violence and Public Health  
October, 1985*

friends or family know about the violence in my home. Please ask me if I am separated or divorced and take time to ask what happened. Ask me about my kids. Be curious and ask if their Dad or Step-Dad loses his temper with them. Ask me if I was an incest victim as a child, if I ever saw my father beat my mother, or if my parents ever beat me.

Let me know that you believe in me. Let me know that you have the confidence in me that I don't yet see in myself, to do in time what is right for me and my kids. Ask if my husband is willing to get help. Know that I may love him and sometimes he's a "great guy." He is my husband and the father of my children. Tell me you can help me by referring me to the appropriate people but, don't suggest couple's counselling because I only get hurt there too. Let me know that I am not alone and I don't have to wage this war by myself. Give me a pamphlet to read about domestic violence, but make it small enough so that I can hide it if I have to. Give me a safety plan so I can begin to think about ways to protect myself. Offer to have your nurse help me make a difficult call, fill out paper work, or talk with me after we have finished. Ask the nurse to call me tomorrow to check on me, but know that I may not be able to talk just then. Be willing to talk with me about "things" the next time I see you. Please above all don't pretend or assume that things are better just because I say they are!

Dear Doctor, I wish I could tell you how much I appreciate your concern and interest. I may not be able to show you how I feel, but



### **Doctor: Here's the first step to help the victim:**

A small, easily hidden pamphlet is available to physicians.

The Denver Medical Society Auxiliary with the aid of the Denver Medical Society have written and produced this informational help guide titled *"No One Deserves to Be Hit"*.

The best place for this information is the women's restroom(s) and your examining rooms.. Many victims of abuse may be wary and /or ashamed to ask for help. They want this material, but do not want to be identified as needing it. To obtain information, pamphlets or to schedule an in-service 30-minute staff training on physical and mental abuse, contact Connie Platt at (303) 355-4793, Patti Brown at (303) 794-1023

or the Denver Medical Society office at (303) 377-1850.

Additionally, the Colorado Domestic Violence Coalition has made available a resource card listing services for victims of domestic violence and elder abuse. These cards are available (100 for a \$5 donation) by calling the coalition at (303) 573-9108

In a non-threatening manner, information on where to find help in our community is provided. The pamphlets and cards are the first step in informing and motivating victims of domestic violence that someone cares and help is available.

Your call may be the first step towards the end of a cycle of violence.

inside I am beginning to trust just a little. I am beginning to see that there is a way out. I am beginning to see that what is happening is wrong and we all deserve better, my children, myself and even my husband. Your kind words, gentle manner and genuine concern have made a difference in our family. With your help, we are taking the first steps to ending violence and walking a path of peace.

Sincerely,  
A Survivor of Family Violence

# Domestic violence requires concerted

“...Anyone who lives in a violent home experiences an essential loss. The one place on earth where they should feel safe and secure has become a place of danger... the shadow of domestic violence has fallen across their lives and they are forever changed.”

*United States Attorney General's Task Force Report on Family Violence, September, 1984.*

In Colorado, over 400 people have been killed along the Front Range due to domestic violence between 1987 and 1991, according to a 1991 report prepared by the Colorado Trust. Hundreds more are physically and mentally disabled or die as a result of the “complications” of abuse. Reported incidents of abuse are on the rise and more and more women are seeking services from shelters.

Jan Mickish of the Colorado Domestic Violence Coalition attributes the rise in reported cases to increased publicity about domestic violence and an increased willingness on the part of the criminal justice system to enforce assault and harassment laws. Mandatory arrest statutes in many local jurisdictions also fuel the rise in reported cases.

## **Health Care Providers are Responding to New Mandates**

Colorado hospitals, physicians and nurses are joining the ranks of health care providers nationwide who are offering added support and more informed assistance to victims of family violence.

The impetus for this commitment is twofold. First, there is growing awareness in the medical community that often, health care providers are one of the first “helping” professionals to come into contact with victims (and often, with perpetrators) of domestic violence. Second, there are legal and regulatory mandates.

Colorado law requires physicians to report injuries which they suspect are a result of a criminal act. Also, the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) recently issued new standards for hospitals relating to the

care of victims of spousal and elder abuse who come to emergency rooms. The standards became effective in 1992.

## **Community Intervention Efforts**

Health care providers, local law enforcement personnel, judges, district attorneys, shelter operators, and counselors of both victims and perpetrators, are getting together voluntarily in communities throughout the state to arrange more coordinated and effective community responses to this complex and serious problem.

Community efforts arise both because of more stringent legal requirements and because people are beginning to understand that often, if an entire community unites in a belief and intention that certain behaviors are not to be tolerated as part of the social norm, such behaviors will change. Advocates recognize that changes must come through individual commitment and awareness, new institutional responses, and through both policy and law. Examples of successful community efforts involving new awareness, coupled with policy and legal changes include local projects attacking drug abuse, tobacco use and gang violence. These are models which can work for family violence too.

Deborah Haack, coordinator of the Family Violence Prevention Program at the Colorado Department of Health's Injury Control Program, is extremely heartened by the growing grassroots movement against domestic violence and the new willingness of the health care community to participate. Since 1990, Haack has worked with the Colorado Domestic



# community response



**COLORADO**  
**DEPARTMENT**  
**OF HEALTH**

by Deborah Haack, Family Violence Prevention Coordinator,  
and  
Jackie Starr-Bocian, Public Information Specialist

Violence Coalition on a training project to increase the knowledge of health care providers about domestic violence so they can work more effectively with clients and also become part of community-wide prevention and intervention strategies.

A manual, ***Domestic Violence: a guide for Health Care Providers***, was developed for the training. It includes information about the cycle of violence, the applicable Colorado statutes, insight into the behaviors of both survivors and perpetrators, and techniques for detection, assessment and appropriate referral of victims to additional community services and resources. The manual was provided to participants at the 1991 CMS Annual Meeting Education Program on Domestic Violence. While the manual forms the backbone of the training, the real work is done in communities, where health care providers meet with law enforcement officials, shelter operators and others to develop protocols and policies for abuse victims.

Since 1990, 14 training sessions have been held in Durango, Cortez, Breckenridge, Fort Collins, Greeley, Glenwood Springs, Denver, Steamboat Springs, Cañon City, Grand Junction, Colorado Springs, Boulder, Yuma and Gunnison. The training was financially supported in part by a grant from The Colorado Trust. Over 1600 people participated.

An evaluation of the community changes that occurred after the training shows an increased awareness regarding the issues surrounding domestic violence; ongoing training and community education programs; increased information in newspa-

pers; and in several communities, an increase in reporting of cases to law enforcement officials. All of the respondents in a six-month follow-up interview commented on their own increased personal awareness and commitment. Another community indicated that the training enabled a group of participants to establish a cooperative network of committed people.

## **New JCAHO Standards: How Colorado Hospitals are Responding**

In April, 1991, the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) issued new standards relating to the care of spousal and elder abuse victims. Since most Colorado hospitals are JCAHO-accredited, they must now put policies into place to meet the new requirements.

Once again, the Family Violence Prevention Project and the Domestic Violence Coalition got together. They convened a Protocol Development Task Force in response to the new standards. The task force included emergency room nurses, counselors of victims and perpetrators, hospital staff, medical societies and others. This task force undertook two major projects: it developed the *Reference Document for Colorado Hospitals: Suggested Protocols for Victims of Spousal and Elder Abuse* to assist Colorado Hospitals in developing local policies and procedures and a companion videotape, featuring emergency room personnel from several Denver hospitals.

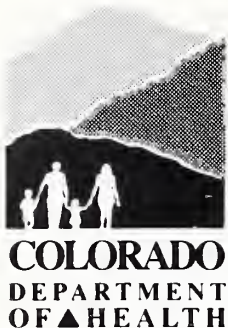
The 30-minute training tape recreates three likely emergency room scenarios, interspersed with commentary. The videotape was

produced with funding from several Denver Metro-area hospitals, the Colorado Medical Society and The Colorado Trust.

The protocols were distributed throughout the state in early summer, while the videotape was finished in August, and is now being used by hospitals and other organizations. Already, the materials have given rise to new and unique efforts in many hospitals, efforts which mirror the "community approach" to domestic violence within the hospital itself.

## **Rose Medical Center**

Rose Medical Center has provided in-service training to emergency staff by showing the videotape and educating staff about ways to identify victims. Managers of personnel within the hospital have also been given in-service training to help them recognize potential victims among their own staff. Beverly Husted, a member of the Center's Public Relations team, says increasing awareness among staff and management "really brings the crisis home". Attending physicians are also becoming involved. Dr. Bob Wall, who is Chairman of the Gyn/Ob Department, has scheduled Grand Rounds devoted to domestic violence. The incoming President of Rose Medical Staff, Dr. Stephen Shogan, who is both a neurosurgeon and an attorney, is working with Denver Medical Society and the hospital to increase staff awareness of legal issues. Rose is also working with Denver's SafeHouse to get a better idea of what shelter workers think the medical community should know about domestic violence.



# Community Response

## (cont'd.)

### St. Mary's Hospital

In Grand Junction, Barbara Lacey of St. Mary's Hospital says that the hospital is taking a multi-pronged approach. Realizing that the emergency room was seeing people in an "acute" phase of the cycle and now always identifying abuse as the precipitating cause of injury, the hospital is hoping to incorporate a screening tool in its routine admissions and medical history procedures, which will be used to ascertain whether clients are at risk of becoming victims. A "danger assessment" tool, a copy of which can be found in the protocols, will be administered to those identified as being at risk and, if necessary, appropriate interventions would be used, including referrals to community resources and follow-up after discharge. The hospital has also received a grant through the Victim Assistance and Law Enforcement program to hold a conference for health care providers, law enforcement officials, members of the county social services department and others.

### The Colorado Medical Society

The Colorado Medical Society is also embarking upon a domestic violence project. In September, 1991, the CMS House of Delegates approved a resolution which created a family violence task force. This task force recently completed a survey of physicians which found that three broad issues are key barriers to physician involvement: frustration with lack of response from patients; lack of knowledge; and the failure of other systems, particularly social services and judicial. According to Marilyn Barton of CMS, physicians

### Consider the prospect of domestic violence if any of the following are observed:

1. Suicide attempt
2. Evidence of alcohol or drug abuse
3. Vague or non-specific physical or psychological complaints (i.e., fatigue, anxiety, depression, "nerves", fearfulness, sleeplessness, rage, loss of appetite and dissociation.)
4. Extent or type of injury inconsistent with patient's explanation
5. Repeated use of Emergency Department services
6. Multiple injuries in various stages of healing
7. Problems during pregnancy, specifically, pre-term abortion, bleeding, interuterine growth retardation, hyperemesis and any other injuries
8. Sites of injury - face, neck, throat, abdomen, genitals or bilateral extremity injuries
9. Eating disorders
10. Report of self-mutilation
11. Self induced abortions or multiple therapeutic abortions or miscarriages
12. Single car crashes, victim may also be a passenger
13. Lacerations and burns
14. Emotional abuse or marital discord observed by staff

consistently noted that patients don't tell them, don't want to implicate partners, won't file charges and don't change their lives. Many physicians did acknowledge that they do not routinely query patients about the occurrence of domestic violence.

The respondents said they need more information on local resources, legal responsibilities, appropriate interventions and better skills for recognizing victims.

CMS will attempt to meet physicians' informational needs by developing and disseminating a variety of resources. Additionally, a multidisciplinary roundtable meeting is being planned to 1) identify and clarify each agency's role; 2) clarify the existing domestic violence reporting statute; 3) identify problems with the current system for dealing with domestic violence; and 4) problem solve.

### Colorado Department of Health Response

Colorado Department of Health Executive Director Dr. Pat Nolan has asked the Family Violence Prevention Program to share the video and related materials with other health department programs.. There are plans to work with other related state agencies in the future.

Dr. Nolan explains her strong support for projects targeting family violence by stating that if we, as a society, continue to accept violence between men and women, then our children will become the next generation of abusers.

Copies of the manual, training video and suggested protocols are available for purchase by calling 1-8000-368-0406. For more information on the Health Department's project, Deborah Haack can be reached at (303) 692-2589.



# Domestic Violence:

## Do you know ...



### Family Violence Awareness Quiz

- |  |                               |                                |
|--|-------------------------------|--------------------------------|
| 1. Family violence affects only a small percentage of the population.      | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 2. Family violence occurs mostly in lower socioeconomic.                   | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 3. Women are most often the victims rather than the perpetrators of abuse. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 4. Children who are abused often become abusers themselves.                | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 5. Alcohol and other drug abuse cause violent behavior.                    | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 6. More than one million older Americans are abused by family members.     | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 7. Homicide is among the five leading causes of death in childhood.        | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 8. Physical abuse is the most harmful form of abuse.                       | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 9. Disruptive behavior may be a signal that a child is being abused.       | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 10. Family violence can be prevented.                                      | <input type="checkbox"/> True | <input type="checkbox"/> False |

### Answers

1. False. Family violence touches the lives of more than 60-million Americans each year, and as many as one-fourth of all American families. As many as 35% of women who visit hospital ERs are there for symptoms related to ongoing abuse. But as few as 5% of domestic violence victims are identified each year.
2. False. Family violence cuts across economic, racial, age, sex and other barriers.
3. True. While family violence can affect both husbands and wives, women most often are the victims. Estimates are that as many as 4-million women are physically battered each year by husbands, former husbands, boyfriends and lovers. They also are victims of other types of abuse—forced isolation, belittling verbal abuse, threats, intimidation, and restricted access to money, transportation and other resources.
4. True. Violence is a learned behavior and children who live with it learn early. The result may be violence toward siblings or playmates; or sexual abuse if that is part of the pattern. As adults, they may engage in violent behavior, such as reckless or drunk driving, or violence or abuse may become part of their own homes. In that case, the behaviors will be passed on to a new generation.
5. False. Drug and alcohol dependence are among the factors that contribute to family violence, but they are not the cause. Other related factors are stress, crises such as losing a job, financial difficulties, marital conflicts, illness, or the increased dependency of an aging relative.
6. True. Elder abuse can include physical, financial, or emotional abuse, and women over age 80 are the most likely victims.
7. True. The majority of infant victims are killed by parents, relatives, or older siblings.
8. False. While physical harm is often the most apparent consequence of family violence, the resulting psychiatric and emotional problems may last a lifetime.
9. True. Other signs include repeated injuries for which unlikely explanations are given by parents or caretakers, and passive or withdrawn behavior of the child.
10. True. Among ways to help prevent family violence are educating people to spread awareness of the problem and what can be done about it; and supporting the victims of violence through safe houses, crisis centers, and hotlines for both victims and abusers.

# In the age of corporate takeovers...

ED: In our last issue, we began the question and answer session between CMS Executive Director Sandra L. Maloney, the editor of *Copic Topics* and K. Mason Howard, M.D., CEO, and Larry Thrower, President of Copic Insurance Company. The purpose of the discussion: to find out how secure Copic was from corporate takeover and buyout possibilities of successful companies. Here is the conclusion.

**Editor:** *How are the officers of Copic chosen, and how do their salaries and "perks" compare with the PIAA median?*

**Maloney:** What is the current makeup of Copic's governance and management teams?

**Dr. Howard:** As was noted earlier, the Boards of the Trust and the Company are coincident in membership. They are comprised of eleven physicians and three non-physicians. All have been active in various elements of organized medicine; the non-physician members include Copic's President, Copic's General Counsel, and a retired partner of a national accounting firm.

By the way, three of our directors have served as Presidents of the Colorado Medical Society.

Copic asks a great deal of its directors, including a commitment of their time and talent for possibly a full decade.

There is an initial year to determine their interest level and suitability. It is probationary, although they have full voting privileges. After that, as suitable, there is the expectation that they will serve up to three additional three-year terms.

This major time commitment is necessary because they must thoroughly understand the complexities of the medical malpractice insurance industry and the responsibilities of directing what has now become a nearly \$200 million corporation.

They have to develop individual expertise in areas such as insurance company finances, reinsurance, claim management, underwriting and communications.

**Editor:** How are board members compensated?

**Dr. Howard:** Directors spend approximately 15 days per year attending six regularly scheduled

meetings. Three of these meetings require three days, for which directors receive \$1,200. The other three are one-day meetings, and the compensation is \$600.

Additionally, board members serve on committees which typically require half-day commitments, for which they are paid \$300.

There is no additional compensation for Copic Trust service, nor for the considerable preparation time which is required before meetings.

The Chairman of the Board, the President and the General Counsel are employees of Copic Insurance Company, as well as Board members; they do not receive any additional compensation for their Board service.

By the way, we have compared our Board compensation policies with those of other PIAA companies and find that we are slightly below the median level of compensation.

**Editor:** How are the officers of Copic chosen, and how do their salaries and "perks" compare with the PIAA median?

**Thrower:** The members of the Board of Directors establish, on an annual basis, compensation for company administrators. Administrators sign annual contracts, subject to annual renewal by the Board.

In the survey of PIAA companies — physician-operated or controlled carriers similar to Copic — salary comparisons reveal that Copic's Chief Executive Officer receives compensation equal to the average of the other 29 companies surveyed, while the Chief Operating Officer's salary is 16.1 percent below the average for those companies.



# What about Copic?



(Part II of two parts)

In comparing all management salaries with these "sister" companies, we find Copic to fall in a range from 27 percent below the median, to exactly equal to the median; on the basis of overall expense load, Copic's 1991 expenses, at 9.89 percent of written premium, were lower than any comparable company in PIAA, where expenses ranged from 10.2 to 24 percent.

In addition to salary, Copic provides its executives an allowance for business use of a car, business accident insurance, annual medical examination, deferred compensation within the established salary, health and disability insurance, and the same paid vacation time which other employees receive. "Perks" available to the officers of many other PIAA companies — club dues, spouse travel, extra vacation allowance, chauffeur service and "golden parachutes" — are not provided to Copic management.

Copic administrators clearly are paid appropriately, but not extravagantly.

**Maloney:** Has Copic ever been audited by the U.S. Internal Revenue Service?

**Thrower:** Interestingly enough, we've had not one but two recent visits from the IRS. One was a six-hour review of the Copic/CMS benefit plan, and the IRS field agent, at the end of his visit, indicated his complete satisfaction with the structure, management and soundness of this benefit plan for the employees of the two organizations, including health, disability and life insurance, and a qualified pension plan.

The other audit, ongoing after nearly six months, was occasioned for a simple reason:

In 1991 the IRS issued new regulations which changed its historic method of taxation for "start-up" insurance companies. As a result of these new regulations, Copic filed amended tax returns requesting a tax refund of approximately \$4 million. Any refund request of this magnitude must be accompanied by an IRS audit of the company seeking the refund.

As you would expect, Copic is cooperating fully with the IRS auditors and believes its refund request will be approved. If it is approved, it will strengthen the Company's already sound financial position.

**Maloney:** I've heard about a Copic Foundation. What is it?

**Dikeou:** Copic Medical Foundation is its full name, and it was established in late 1991. It is a private 501(c)(3), federally-approved tax-exempt, non-profit Colorado corporation which must comply with Colorado and Federal law in carrying out its non-profit purposes. The Foundation must use its assets and income to support other 501(c)(3) entities or for state or federal governmental purposes.

The sole purpose of this Foundation is to benefit and provide support for various charitable, educational, civic and scientific purposes related to medicine, medical education, medical research and other medical charitable purposes.

Currently intended beneficiaries include the Colorado Physician Health Program (CPHP) and the

Colorado Personal Education for Physicians (CPEP).

**Editor:** How is Copic Foundation funded?

**Dikeou:** Initially it received \$1 million out of surplus Copic Trust funds. When the Trust finally runs off its last remaining insurance-coverage obligations, any remaining assets may be suitably placed with the Foundation — to be used for the betterment of medicine and physicians in this state in accordance with the Foundation's charter documents.

**Editor:** *We've covered a lot of ground. Sandra Maloney, you fired the first question, so it seems appropriate that you field the last question. It is: "Well, what do you think about Copic, particularly as it interfaces with CMS members?"*

**Maloney:** *"I really don't intend this to sound like a commercial, but the fact is: I think there is every evidence that the long-standing relationship between CMS and Copic is just as solid and mutually productive as ever. Maybe more so."*

# CMS Leadership Conference

*Note: Last month, the exec. of the El Paso County Medical Society waxed eloquent about the value of "Elmers", those component societies who hold organized medicine together. Now, as promised, is the exciting conclusion.*

I'll bet you can tell by what I wrote last month that I'm excited about what I do and I'm very proud of the people I work with. A doctor once told me he didn't want to join because the society was just a good old boys club. I guess you could still call our retired physician task force that. Otherwise that's getting to be an obsolete expression in most societies. I know that societies still have a lot of work to do in order to organize so that opportunities to become more active can be tailored to meet the needs of young physicians and women but, it can be done. In our society half our board of directors will be women this coming year.

In fact, I'm always amazed at how willing most of our members are to give their time and their support. All of you here today are an especially good example. You've taken time from your practice and your family. And you've taken money from your pocket in order to be here on behalf of your profession. You all know very well the great benefit your colleagues receive from the time you donate. And, I imagine you're here because some one did the same for you at one time or another.

Well, if components are the glue that holds the federation together, then committees are the glue that solidifies county societies. The medical execs and the presidents have to be talent search persons... Getting the best from everyone. All members have some expertise in certain areas and interests in a lot of others and there's a lot of competition for that interest and expertise.

Most societies have committees to address everything from aids to zoology and it takes a lot of volunteer hours to accomplish the great projects that end up getting done.

Since our topic this weekend is the Physician in the Year 2000 I guess we better take a few minutes to look at what we need to do for the future. Whatever that turns out to be I think we better get to doing it soon since the year 2000 is well within touching distance!

I really wish we were having this discussion about a month from now; I'm sure I'd be brimming with great ideas and charged with enthusiasm. We're having our annual AAMSE meeting the end of July to address just this subject. But, to get some ideas for this weekend I've talked with a lot of my colleagues in advance and here's a list of a few things they think will need to be addressed:

You know your profession is changing and that it will be a lot different just eight years from now. As the practice of medicine changes so will the role of the medical society; doctors will more and more need an organizational structure which can negotiate and lobby for them...The federation of medicine is that structure but, without the component societies you'd have a difficult time letting your negotiating arm know what results you want.

It's more and more vital to bring a positive description of doctors to the public. We'll have to find new and innovative ways to do that on all levels. We really need to brag, to our members and to the public, on all the great things that get done through



# "The Physician in the Year 2000"

Carol A. Walker  
El Paso County Medical Society

organized medicine. Most of us do a poor job of that.

We *have* to become more involved politically. One reason we don't have more physician lawmakers is the same reason we don't have a variety of people in public office; they need to make a living. To help solve this, what if we formed a national foundation. Funds could be dispensed through the foundation. Funds could be dispensed through the foundation to provide locum tenens during the time the physician lawmakers are in office.

We need funding for all these programs and activities and we can't get it all from dues. We have to look at programs that can save or make our members money, or at least make paying dues less onerous. I think a national travel program is a good idea. Can you imagine the discounts we could negotiate if we could deliver even 50,000 doctors, their families and their office personnel?

We have to have some solid membership recruitment and retention programs. They should be joint with the national, state and local societies. I'd like to see the state society fund a part time person that would work for each district. That person would call, in person, on each member of the society and all those doctors who aren't members of the society. They wouldn't have to be an expert on the workings of the society. Their job would be to gather information and report back. There wouldn't be much expense involved especially when compared to the invaluable member relations we could begin to develop.

For public relations maybe we should develop a national referral service and start it off with a huge national media blitz. It would be provided through the county societies, coordinated through the states and financed through the national society.

Component societies have formed many coalitions in their communities. These should be expanded to include the state, then should involve the nation as a whole in order to identify and then resolve problems with seniors, uninsured, underinsured, payment systems and all those things we can't fix by ourselves.

The federation of medicine is that three legged stool we hear so much about... We just can't be balanced without the national, state and component societies. We must truly improve the coordination of all our activities and begin to speak with a common voice. Somehow we have to come to agreement of a slogan and then five that same message to doctors and to their patients and that message should be carried on member ties, scarfs, logos, pins poster and plaques, bumper stickers and anywhere else we can think to put it!

I think all this will keep us busy for awhile. However, to get any of these done though there are three things that we can never forget and those are:

.....Communicate; Commu-  
nicate; Communicate.....

*"The federation of  
medicine is that three  
legged stool we hear so  
much about..."*

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# The Interview

A short story (Part II of three parts)

by **Joe Batuello, MSI**  
Denver, Colorado

What if you botch...**THIS**,  
and the patient doesn't die  
like he's supposed to?"

*When we left our story in Part I, Alex Bookman was listening, nervously as Dr. Zyklon (with whom Alex was interviewing for a possible residency) had launched into an enthusiastic description of the program.*

"This is the specialty of the future, Bookman. Think of it: thousands of terminally ill patients facing a life of what? Pain, machines and Medicare! Any questions?"

Alex thought for a moment. "How do you know if..." He paused for a second, not knowing if "euthanasia" or "physician assisted suicide" were sensitive terms. "How do you know if...THIS is appropriate for a given patient, and that you don't just have some despondent...person?"

Dr. Zyklon's brow wrinkled thoughtfully. "Well, we have a team of crack psychiatrists or psychologists or something to evaluate each patient. Of course, we're not here to judge. There are circumstances in everyone's life that may make...this appropriate. This is about choices, escape from pain. We're here to provide a service."

"Of course," agreed Alex, trying to be delicate, "and I can see where that would be appreciated if the Broncos go to another Superbowl. But why doctors? I mean, anyone can do...THIS. Can't they?"

Out of the corner of his eye, Alex saw Mr. Carlucci smile faintly. Dr. Zyklon seemed irritated.

"For God's sake Bookman! We're professionals. You could pull your own teeth too, but do you? No. You go to a dentist. Christ, the last thing we need is a bunch of amateurs and do-it-yourselfers running around giving us all a bad name. We do things right. We

have the equipment and expertise. The patient can just sit back, relax, and enjoy the trip. I mean, if you can't trust your doctor, who can you trust?"

Dr. Zyklon thought for a moment, then added, "Leave death to the professionals." Alex recognized the last line. It was spoken by Trevor Howard in "The Third Man."

"I see," offered Alex meekly, "but pharmacists make mistakes, machines malfunction, ...doctors goof. What if you botch...THIS, and the patient doesn't die like he's supposed to?"

Mr. Carlucci leaned forward, pantomiming with his thumb and index finger extended, "Hey, sometimes...BA-DA-BING! ... You do what you gotta do, y'know what I'm sayin'?"

Dr. Zyklon smiled paternalistically. That's why this is a three year program; so these types of things don't happen."

The interview continued more or less in this fashion for another 20 minutes, with Alex and Dr. Zyklon not exactly hitting it off. Alex wondered if the residents would call Dr. Zyklon "The Terminator" behind his back.

As the interview concluded, Alex was given a tour of the facility. At the end of a long corridor was the "procedure room" where thanatological science turned theory into practice. This surprised Alex somewhat, since he had imagined that patients would be dispatched from their rooms.

Just outside the procedure room was hung a Norman Rockwell print, the one showing a young boy in a doctor's office with his backside exposed as the doctor prepared to give him a shot.

(Continued in **Part III**, January '93)



# Medicaid miracle in Mesa County



by Roger C. Shenkel, M.D.

*"Physicians are provided major financial incentives for seeing these patients in their offices..."*

**For 20 years, Medicaid has been under control** in Mesa County, Colorado. You probably haven't heard much about it. Here is the story.

Since 1974, Rocky Mountain HMO has had an at-risk contract with Medicaid. The program here has cost the State less than it does in the rest of Colorado. Medicaid patients have access to all local physicians, and nearly all physicians have continued to participate in the program. We have never run out of money for physician fees, and we smugly grin as it consistently happens elsewhere in the State. Medicaid patients have access to all local hospitals. Why haven't you heard about it before? You would think that 20 years of successfully managing Medicaid would make headlines. The program has not been politically correct from the medical and legislative viewpoint. First of all, it began in 1974 with a strict gatekeeping philosophy. That was frightening to many in organized medicine at the time, and most of our representatives to the Colorado Medical Society were specialists. We looked closely at utilization and quality and it so happened that early on one of the physicians dropped from the program was very prominent in a State medical organization. We paid Primary Care Physicians fairly well for their efforts to make the program run efficiently, and that money was always perceived as coming at the expense of the specialists. To address the huge amounts that pharmacy was costing our Medicaid patients, we entered into an exclusive agreement with a

pharmacy chain. The local pharmacy group fought this effort vigorously at the State level and sullied our reputation with the legislature. And probably the biggest reason that no one in organized medicine has said much good about us is that the key to our success has been spelled H-M-O. There seems to be a perception with physicians that because some HMOs behave irresponsibly, all do. So it is no surprise that you do not hear much about Mesa County's solution to Medicaid.

Here is what we do. If you sign up for Medicaid in Mesa County and opt for the HMO plan, all physicians who are taking any new patients will accept you in their practice. You are then tied into a tight gatekeeping system—tight in that you cannot bypass it, but very loose in that virtually all local specialists participate and are available with an appropriate referral. Drop-in ER visits by Medicaid recipients seem to be unstoppable, but local hospitals, after some arm-twisting, have given us reduced rates for these visits. Physicians are provided major financial incentives for seeing these patients in their offices or local convenience rooms (provided by the hospitals free of charge), rather than seeing them in the emergency rooms.

For 20 years, physicians have been paid the same fees for Medicaid services that other lines of HMO business are paid, less a withhold, that can be as high as 40 percent. At a 40 percent withhold, our fees are about the same as straight State Medicaid payments. Most years, a portion of the withholds have been



## miracle ...

(Continued)

paid out resulting in payments to physicians above the Medicaid schedule. Administrative hassles are greatly reduced, so most physicians are happy to participate. Of the 20 years, there have been only two where the 40 percent withhold has not protected the HMO from losses. Most of our major problems happen when the State unilaterally changes the agreement. A prime example was 1990 and 1991 when the financial requirements for pregnant women to enroll in Medicaid were lifted without an adequate adjustment to compensate for the high costs of the group. Both years the doctors lost their 40 percent, and the HMO lost significant reserves.

Is it perfect? Of course not. The Medicaid group defies any attempts at consistent preventive care and will always be a utilization frustration for caregivers. The State will never have enough resources to adequately fund the system. But do we have enough resources to adequately fund the system. But do we have a model that provides universal access for all Medicaid recipients, provides quality cost-effective care, and is acceptable to Mesa County physicians and patients alike? **Yes, we do.**

**NOTE:** Roger Shenkel, MD., is a family physician in Grand Junction, Colorado. From 1987 to 1992 he was President of the Mesa County Physicians Independent Practice Association, an IPA that contracts on behalf of 140 Mesa County physicians with Rocky Mountain HMO for the Medicaid program in Mesa County.

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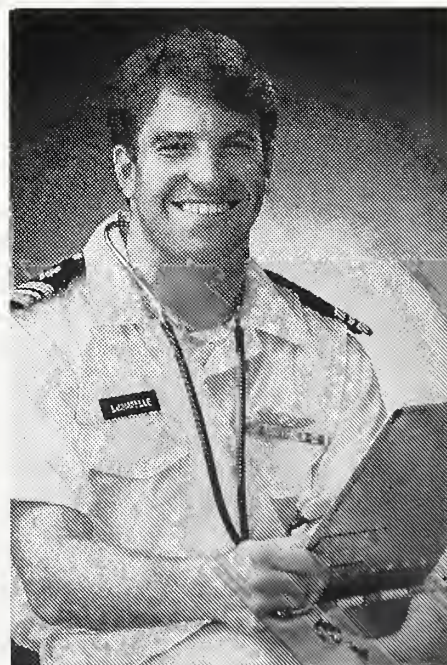
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# 3 million to improve rural health services

*Lindy Nelson, Rural and Primary Health Policy Director, Colorado Department of Health*  
*Peg O'Keefe, Vice-President of Public Affairs, Colorado Hospital Assn.*

Twelve hospitals throughout Colorado have been awarded \$200,000 each from the federal Health Care Financing Administration to participate in a program to improve rural health delivery.

Six small rural hospitals are being paired with six larger, more fully equipped facilities in an effort to reduce fixed costs and avoid duplication of services, while improving care for patients. The facilities are:

## Proposed Primary Care Hospitals (PCHs)

Weisbrod Memorial Hospital in Eads.	with
Haxtun Hospital District in Del Norte	with
St. Joseph's Hospital in Del Norte	with
Rangely District Hospital in Rangely	with
Pioneer's Hospital in Meeker	with
Kremmling Memorial Hospital	with

## Proposed Essential Access Community Hospitals (EACHs)

Arkansas Valley Regional Medical Center in La Junta
Sterling Regional Medical Center in Alamosa
San Luis Valley Regional Medical Center in Alamosa
St. Mary's Hospital in Grand Junction
Valley View Hospital in Glenwood Springs
Routt Memorial Hospital in Steamboat Springs

## **EACH/PCH**

The Colorado Department of Health has received \$500,000 to implement the program in the state, with the assistance of the Colorado Hospital Association. Over the next two years, the facilities will make the changes necessary to be classified as either Essential Access Community Hospitals (EACHs) or Rural Primary Care Hospitals (PCHs).

Colorado is one of only seven states (out of 21 applicants) selected to participate in the program to improve rural health services.

The smaller, Primary Care Hospitals are required to downsize to no more than six beds and keep patients for an average of 72 hours. Emergency service will be available 24 hours. These facilities will have a formal agreement with the Essential Access Community Hospital for transfer of patients, provider back up, quality assurance and information sharing.

"The intent of the program is to assure access to health care by reducing the risk of smaller hospital closures," according to Lindy Nelson, director of the Rural and Primary Health Policy and Planning Section of the Health Department. "By pairing them with hospitals nearby, the smaller hospitals will be able to reduce overhead costs, which will help them to remain open and provide service in their communities."

The facilities will use the grant money to meet criteria in order to be designated an EACH or a PCH. For example, the Primary Care Hospitals plan to buy tele-radiology equipment so x-rays may be sent electronically to their larger partner hospital to be

reviewed right away, instead of waiting for the weekly visit from a radiologist. Some of the hospitals also plan to buy electronic data equipment so patients' records will follow them if they are transferred to the partner hospital. This can prevent tests from being repeated and will improve communications between physicians.

Each hospital will set up a community advisory board to help in the process. The Emergency Medical Services Division of the Colorado Department of Health will provide technical assistance in the development of criteria concerning the transportation of patients between the hospitals and development of telecommunications systems. "This rural health network program will help rural hospitals continue to meet the needs of their communities," according to Larry Wall, president of the Colorado Hospital Association. "The challenges facing rural hospitals are many and by networking with larger facilities, assistance in reducing those problems will be realized."





Edie K. Register, Director

## Unnecessary Denials

Due to Physician Payment Reform, the use of modifiers has become very important. The Colorado Medical Society (CMS) has received numerous complaints from physicians concerning necessary care being denied. After researching a number of individual cases I have found that the majority of denials are caused by a missing modifier and in some cases a modifier being used when it is not necessary. Let me give you a few examples of what I am seeing.

### Example 1

Mrs. John Doe calls for an appointment because she has a sore on her foot and thinks it might be infected. Based on your visit, you determine that is necessary to perform an incision and drainage immediately. The proper billing procedure would be to list you Evaluation and Management code with the modifier 25, because the decision to perform the surgical procedure was made on that day. Also make sure you document in your medical record that the decision to do the procedure was made at that visit. You would also bill for the incision and drainage without a modifier.

**Note:** If the procedure is not performed at the same visit, but is scheduled to be done at another encounter, the subsequent visit scheduled to perform the procedure cannot be billed.

### Example 2

An oncology clinic was billing for weekly radiology therapy man-

agement; complex (procedure code 77430). The therapy was performed in a hospital and the modifier 26 was attached to indicate professional component. After thousands of dollars in denials and numerous phone calls to the Carrier, the clinic contacted CMS. After a meeting with Jan Popovitch at the Carrier, we determined that modifier 26 is not applicable to code 77430. Do not assume that all radiology or diagnostic testing codes have a professional and technical component modifies applicable to them. To determine which codes do and do not have professional and technical components, review you disclosure (charge limit) reports that the Carrier mails each year with the Dear Doctor Participation Letter.

CMS members are encouraged to contact Edie Register at 779-5455 or 1-800-654-5455 if they have questions concerning denials and feel they are not receiving adequate explanation from the Carrier.

*The majority of denials are caused by misused modifiers*

## Use of Modifier -24

*from the Medicare Carrier*

Carrier reporting to the Health Care Financing Administration on the use of modifier 24 shows an increase of over 4,000 percent from January to June of 1992. The number of physicians reporting the modifier also increased over 2,000 percent from January to June.

Modifier 24 is used to report **unrelated visits** during the postoperative period of a surgery by the operating physician. The modifier should be used only with **visit codes** (E&M), and should not be used with surgical or diagnostic procedures, or with lab, x-ray or anesthesia services. Since the modifier pertains only to the operating surgeon, it should not be used by the assistant surgeon.

E&M services for related diagnoses, even though reported with a different ICD-9-CM diagnosis code are considered related services and should not be reported separately. Examples: eye pain after cataract surgery or urinary retention after a TURP.

# OSHA Update

By Bonita Carson, M.D.

*I hope this update is useful. If you have further questions please contact me at 303-781-5301 or Ellen Stein at CMS 303-779-5455.*

I hope you won't think that I've gone over to the other side. It's just that, as a consultant to the regional OSHA office, I am able to stay current with the agency's activities relative to the Bloodborne Pathogens Standard.

The Exposure Control Plan and your employee's knowledge of the Standard remain the objects of the OSHA inspectors' closest scrutiny when checking for compliance with the Standard for Bloodborne Pathogens. I have learned that some inspectors expect you to have a detailed procedure for investigating, documenting and correcting problems surrounding an exposure incident. The Incident Evaluation Form from the CMS "Office Compliance Manual" which we prepared last spring demonstrates a first-step, "good faith" effort to meet this requirement and may satisfy some inspectors, but not all. It would therefore be wise to state in your plan as many specifics as you can regarding how an exposure incident will be handled in your facility (e.g. who will do the investigating, who will do the post-exposure exam, etc.) The good news is that omission of this amount of detail would constitute a very minor violation and, unless it was part of a large group of violations, you would probably have 30 days to correct it.

In our Region 8 between December 6, 1991 and September 30, 1992, there were 9 inspections of large facilities, and no inspections of private offices.

Two inspections were planned in general manufacturing to address first aid workers, one was a referral and six were based on employee complaints

These last fall into 2 categories:

**Formal** - Employee must be current and must sign a complaint; the OSHA inspection may occur immediately with no notification; the employee complainant is sent a copy of the results of the inspection.

**Informal** - Current or former employee makes a complaint but does not sign the complaint. In this case, the employer is sent a letter and has 30 days to respond to OSHA; if the response is unsatisfactory, OSHA will conduct an inspection

OSHA officials have received many phone calls from employees seeking to complain but most are reluctant to file a complaint.

The nine inspections yielded nine violations. Five were not serious and four were considered serious. The average penalty was \$1,100. The compliance officer determines what type of violation will be cited. Minor violations are not too costly, but if there are many minor violations they can be grouped and cited as serious (maximum penalty \$7,000). A willful violation (e.g., the employer refused to offer the Hepatitis B vaccine and the employee becomes infected in the workplace) can cost up to \$70,000.

One final note regards employees who received vaccine before the statute was in effect. The employer must have documentation such as a medical record or written opinion that the employee received the vaccine. The simplest way to do this is to have the employee sign the statutory declination form (included in CMS packet) indicating that they are declining because they have already been vaccinated.



# The life and times of a locum tenens

By **Richard F. Bedell, M.D.**  
Boulder, CO



## What's it like being a "Rent-a-Doc" ?

Many physicians have asked me this question, knowing I entered the locum tenens field two years ago. How do you find locations? Is licensing a hassle? Is it hard to fit into another practice? Where do you stay?

After 28 years in private pediatric practice in Boulder, I was ready for a change and longed to travel. What better way than to become a locum tenens and be able to plan my locations, vacation and time? Soon, I had signed with CompHealth, the largest among many locum tenens firms. After sending them notarized copies of every license, diploma and certificate imaginable, plus a half dozen references to call, I was off and running.

CompHealth helped me obtain and paid for my licenses in four states initially (now eight). They match physicians in all specialties with practice locations, arrange all travel and provide lodging (usually a furnished apartment) and rental car at the assignment. Also, they provide malpractice insurance, and help arrange hospital privileges by furnishing all documentation and references. Some states require personal interviews; many require 20-50 hours of CME annually; some require an AIDS course or a Risk Management course. The company helps to arrange all this.

Who needs a locum tenens (Latin: one holding a place) ? I have worked for many types of practices—private, groups, government clinics and HMO's—from Colorado to Massachusetts. Physicians have been on vacation, looking for a permanent

associate, post-partum, ill, taking CME courses, and in Saudi Arabia during Desert Storm.

Assignments are for two to eight weeks, averaging a month, and then I return home for a few weeks. In between locum tenens assignments, which I am free to accept or decline, I often work as a volunteer in Mexico or India. Frequently my wife comes to visit during part of my time away from home. I am always warmly welcomed on assignments and have learned to enlist the aid of nurses on the first day. I attend local Rotary Club meetings, churches, and often have meals at doctor's homes. On weekends I become a tourist with camera at the ready.

My maiden journey was to the eastern shore of Maryland where I replaced the only pediatrician within a 50 mile radius who was off to England for a few weeks. He had no answering service, but an answering machine whose idiosyncrasies were only surpassed by his dogs. I stayed in his home. Stuffed with seafood, I then ventured to suburban Colorado to again cover a solo practice whose owner was in Florida arranging for his relocation. His staff, but not his patients, had been notified of his intended immediate departure, so an extra measure of diplomacy was needed.

Inner city Boston was a different experience. I was a minority by race, gender and professional status. Most "Health Care Providers" were nurses or P.A.'s. In Adolescent Clinic three questions appeared on the intake history: (1) When was your last fight?, (2) Were you injured? and (3) Do you carry a weapon? Most

- (1) *When was your last fight?*
- (2) *Were you injured?*
- (3) *Do you carry a weapon?*

answered "Yes". I appreciated a whole new culture that I had not known.

Locum tenens is a Win-Win situation. As a provider I can practice medicine which I love, and also pursue other interests. I am free of administrative hassles and collect a per diem check for my services as an independent contractor. The clients have an immediate well-credentialed replacement for their time of need with fees generated to at least cover their overhead expenses.

Are there disadvantages? I've lost the continuity of care that I cherished, and the rapport with patients and their families. But I've traded that for a new freedom and the excitement of adventures in new places with new friends.

ED: The Colorado Medical Society is currently organizing a locum tenens program. This service is for the exclusive use of our members. CMS will act as a matching service between host physicians and locum tenens. There is no cost to CMS members for these services.

If you have questions about the program, Please call (303) 779-5455 (in the Denver area) or 1-800-654-5653 (outside the metro area). CMS staff will be glad to assist you

# Courses offered for physician counseling of HIV patients

## *Intensive training on how to deal with the HIV patient.*

In response to the charge given it by the House of Delegates at the 1992 Interim Meeting, the Council on Professional Education has investigated training courses to assist physicians in counseling HIV patients.

The Colorado Department of Health Sexually Transmitted Disease (STD)/AIDS Education and Training Program has developed a number of courses for health care providers involved in the prevention, diagnosis, and treatment of sexually transmitted diseases, including HIV infection and AIDS. Listed are courses that may be of particular interest to physicians.

For additional information regarding these courses, contact the STD/HIV Education and Training Program at the Colorado Department of Health, 331-8310.

The Colorado AIDS Education and Training Center offers an HIV Clinical Training Program for physicians and other health care professionals. The HIV clinical training program is offered as a five-day intensive course. (Shorter courses are available by special arrangement.) The training is individualized, to the extent possible, to meet the professional and practice needs of participants.

The program's goal is to train primary care and mental health practitioners to provide ongoing care to their HIV-infected patients/clients and to increase the number of practitioners in the Rocky Mountain Region working with HIV-infected persons. You may obtain application forms and additional information at 355-1305.

## Courses

### **HIV Serologic Test Counseling**

This 16-hour, two-day course provides participants with the knowledge and skills necessary to do in-depth pre and post test counseling. Upon completion of the course, participants should be able to discuss serologic testing for antibodies to HIV; present pre-test information to clients; counsel clients with seronegative test results using the guides presented in the course; counsel clients with seropositive test results using the guides presented in the course and discuss the notification of sex and needle-sharing partners with seropositive clients.

### **The Psychosocial Implications of HIV Infection and AIDS**

This eight-hour, one-day course is designed to provide participants with a basis for understanding an overview of the psychosocial issues impacting HIV infected individuals. Upon completion of the course, participants should gain understanding of emotional, psychological, social, financial and legal issues of HIV infection and AIDS as it impacts men, women, children, health care providers, families, employers and society as a whole.

### **Managing Stress in STD/HIV Professions**

This eight-hour, one-day course is designed to help STD/HIV professionals recognize forms of job-related stress. In addition, participants will be provided with viable means of managing this condition, through self help or external resources. Upon completion of the course, participants should be able to identify stress as it relates to their jobs and determine if stress levels become so debilitating they should explore methods of stress management. They will also be able to practice simple methods of stress management and will be provided with other resources dedicated to managing stress.



## CQI : A Tool Physicians and Hospitals Can Use Together to Manage Change

### Hyatt Regency DTC, Friday, January 15, 1993

This is a one-day seminar from 9:00 a.m. to 4:00 p.m. at the Hyatt Regency DTC, Lunch and a reception are included in the \$75 registration fee.

Health care professionals are witnessing nothing but constant change and hospitals and physicians are looking for proven ways to respond. Continuous Quality Improvement (CQI) provides the structure to manage change, identify and meet the community's needs, and reduce costs, while incrementally improving the quality of patient care. Continuous Quality Improvement is a tool that does more than just address problems and patient complaints. When used fully, CQI continuously addresses every aspect of health care delivery. CQI is a proven tool for managing change.

Physicians and administrators from St. Mary's Hospital and Medical Center (Grand Junction), Parkview Episcopal Medical Center (Pueblo) and Penrose Hospital (Colorado Springs) will share informative, practical, and exciting ways that hospitals and physicians can work **together** to start or improve a CQI program. This will be a "user friendly" seminar with emphasis on audience participation. The **tentative** agenda is listed below.

8:30 a.m.	Registration
9:00 a.m.	Welcome and Introductions Leigh Truitt, MD, President, CMS
9:15 a.m.	CQI and Its Role in Shaping the Future Sister Lynn Casey, St. Mary's
9:45 a.m.	QA/QI/CQI: The Parkview Story Carol Guinane, RN, MBA, Parkview
10:15 a.m.	Break
10:30	QA/CQI: The Penrose Story Ted Lewis, MD, Penrose
11:00 a.m.	Physician Involvement Keith Wilson, MD, Parkview; Ted Lewis, MD, Penrose; Francis Raley, MD, St. Mary's
12:00 noon	Lunch - Round Table Discussions with Speakers
1:00 pm.	Physician Training Fred Barbero, MD; Barbara J. Sowada, PhD, St. Mary's
2:00 p.m.	Break
2:15 p.m.	Case Studies Pneumonia: Parkview Staffing: St. Mary's CCU Anticoagulant CQI Project: Penrose
3:00 p.m.	CQI: The Leadership Challenge Michael Pugh, President/CEO, Parkview
4:00 p.m.	Wine and Cheese Reception



by Alan Rapp, MD, Chairman,  
Council on Legislation



## The election is over — so what next?

The passage of Amendment 1 is frightening to legislators and perhaps even more so to lobbyists who are responsible for gaining passage of legislation for the groups they represent. We're sure that the majority of you know that the amendment limits the annual growth in most state government spending to the rate of inflation plus the percentage change in state population. For the past five years, the population growth and inflation has been: 3.3% in 1986-1987; 2.85% in 1987-88; 2.2% in 1988-89; 5.2% in 1989-90 and 4.1% in 1990-1991. Legislators face an unprecedented challenge to keep pace with the expanded Medicaid requirements (which are estimated at \$75 million for the newly eligible children), the \$374 million new dollars needed to honor the existing school finance act, and other statutory obligations, such as prisons and Public Employees Retirement Association funding. CMS will be closely monitoring the Joint Budget Committee and will keep you informed concerning the ramifications of this amendment.

The 1992 election substantially changed the composition of the Colorado legislature — there will be 19 Republicans and 16 Democrats in the State Senate and 34 Republicans and 31 Democrats in the House of Representatives. The Democrat party hoped to gain seats during this election cycle but we believe it was a surprise to everyone that the party made such large gains. We can expect to see far more coalition building and compromising if any meaningful legislation is to be passed.

Two long-time senators were defeated in their bids for re-election — Senators Harold McCormick (R), Cañon City and Ted Strickland (R), Westminster. As most of you know, Senator Strickland served as Senate President for the past 8 years. Senator Tom Norton (R) of Greeley has been elected to replace him. The January issue of *Colorado Medicine* will provide you with a complete listing of legislative leadership as well as committee membership.

The Council on Legislation's December meeting will consider positions on proposed 1993 legislation. The proposals of which we are aware are listed below.

**Direct Entry Midwifery.** The direct-entry (lay) midwives once again submitted an application for regulation to the Legislative Sunrise/Sunset Review Committee. The application was approved by the committee and a bill will be introduced which decriminalizes the unlicensed practice of direct-entry midwifery by excluding it from the definition of the practice of medicine. The bill does not immunize direct-entry midwives from other civil or criminal liability, but it does provide guidelines for the regulation and registration of direct-entry midwives.

**Private Utilization Review Organizations.** In accordance with RES 28-P ('89), CMS submitted an application to the Sunrise/Sunset Review Committee for regulation of private utilization review organizations. The committee did not approve regulation but a bill will be



*Sue Ellen Quam, Director, CMS Government Relations  
Lorraine Koehn, Program Manager/Lobbyist*

submitted which provides that any private utilization review entity contracting to provide services for a health insurer, nonprofit hospital, health care service corporation, or health maintenance organization is the direct agent of such regulated entity. The proposal makes the insurer responsible for the activities and functions of private utilization review organizations operating within the scope of any contract.

**Funding for the Colorado Physician Health Program (CPHP).** In response to RES-57-P ('92), CMS is working with Copic and staff of CPHP on legislation which will increase the cap on the surcharge that funds the Physician Peer Health Assistance Fund to \$25.

**Motorcycle Helmets.** The Colorado Motorcycle Helmet Coalition has been formed for the purpose of passing a motorcycle helmet use law in Colorado during the 1993 legislative session. Recent federal highway legislation (ISTEA) dictates that if we do not have a comprehensive helmet use law in place by October 1, 1993, Colorado will suffer a transfer of over \$9 million in highway construction funds to non-construction safety projects.

**Trauma Centers.** We expect Senator Dottie Wham to introduce legislation designating state wide trauma centers. Senator Wham appeared at the November meeting of the Council on Legislation and advised council members that she hopes to work with members of the

medical community to iron out many of the problem areas contained in previous trauma center legislation.

We can also expect legislation dealing with health care reform, confidential HIV testing and uniform billing of insurance claims and we'll advise you as soon as we have details on these proposals. Only time will tell the impact that Amendment 1 will have on any of the proposals included in this report.

*"We can expect to see far more coalition building and compromising..."*

## **PARTICIPATION '92**

*Ben Galloway, MD and Patti Brown, Co-Chairmen*

Two physicians and one physician spouse take the word "participate" extremely seriously — Senator Claire Traylor (wife of Dr. Frank Traylor) is completing her third term in the state senate; Dr. Pat Sullivan has been re-elected to a second term in the State House of Representatives, and Dr. John Elliff was defeated in his valiant effort to become a member of the University of Colorado Board of Regents. Sincere thanks to each of you for becoming involved!

We'd like to express our appreciation to the following physicians and staff who worked on campaigns during the 1992 election:

Rob Bogin, MD  
Patti Brown  
John Buglewicz, MD  
H. G. Butler, III, MD  
Judy Butler  
Ben Galloway, MD  
Diane Glismann  
Suzanne Hamilton  
Becky Hammond  
Richard Hammond, MD  
Lorraine Koehn

Robert Kruse, MD  
Ted Lewis, MD  
James Meewsen, MD  
Carla Murphy, MD  
Robert A. Nathan, MD  
Ray Painter, MD  
Don Parsons, MD  
Sue Ellen Quam  
Bob Sawyer, MD  
Ron Tegmeier, MD  
Leigh Truitt, MD

We know that there are many more of you out there who gave of your time to elect your favorite candidate — please contact the CMS Department of Government Relations and tell us who you are (779-5455 or 1-800-654-5653).



*A monthly report of current and on-going activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.*

**Council on Community Health**

**Issues:** The Council last met in August and reviewed pertinent resolutions being submitted to the CMS House of Delegates. The Council continues to get updates from the activities of each of the committees under its purview. The Council will meet again in November to develop action plans for each of the resolutions passed at the Annual meeting. In addition they will continue development of plans regarding protocols for nursing home directors.

**Sports Medicine:** November 24, 1992 meeting cancelled due to weather. Meeting has not yet been rescheduled.

**HIV Committee:** At its meeting on November 2nd the committee reviewed the HIV Anonymous Test Site Evaluation report. Based on the data collected on 18 months of testing at this site the committee developed a position statement for approval by the CMS Board of Directors.

**Family Violence Task Force:** The committee next met on November 23. A subcommittee is in the process of planning a multidisciplinary forum to 1) identify and clarify each agency's role, 2) clarify the existing reporting statute for domestic violence, 3) identify problems with the current system for dealing with domestic violence, and 4) problem solve.

**Medical Informatics:** In conjunction with the 1st Annual Meeting of the

Colorado Rural Health Resource Center, planned and presented a half day forum on medical informatics in rural areas. The November 20th meeting was held at the new Merck Center for Technology, Education and Information.

**Medical Service Council:** The Council continues to discuss the issue of non-physician providers and will convene a multidisciplinary group to respond RES-47-P on December 11. The proposed locum tenens project was to be finalized at the Council's meeting on December 4th.

**Emergency Medical Care Physician Advisory Committee (EMCPAC):** The Committee continues to work with the EMS division of the Colorado Department of Health and the Coroner's Association to develop recommendations for cessation of resuscitation efforts at the scene. Will also provide recommendations to the Sports Medicine Committee regarding appropriate emergency equipment for high school sports events.

**Codman Small Area Analysis**

**Project:** At its November meeting, the draft of the first report was presented for approval. In addition, membership for a study committee was determined. The study committee will be convened to review the report and determine the questions raised by the data. This information will then be provided to the medical community to assist them in understanding and utilizing the report.





**Hospital Medical Staff Section:** The section sponsored an educational program on CQI/TQM at the CMS Annual Meeting. The section also voted to remain in place and re-elected Dr. Gary VanderArk as its chairman.

**Women in Medicine Section:** The section sponsored a wine and cheese party at the CMS Annual Meeting. RES 45-P Parental Leave, sponsored by the Section has been returned with instructions to develop model policies. The Section has begun work on this project. Other projects planned by the Section include a medical student mentor program, a survey of women physicians across the state and a child care center study.

The **Physician's Health Issues Committee**, chaired by **Bonita S. Carson, MD**, met November 12. Based on discussion, the Committee will begin developing model guidelines dealing with the Americans with Disabilities Act and its effect on the physician credentialing process.

Because of the complexity of this issue, the Committee will request input from a variety of sources, including CMS legal counsel, the Board of Medical Examiners, the Colorado Hospital Association, the Association of Medical Staff Services, the Colorado Foundation for Medical Care, physician chairs of local hospital credentialing committees, representatives from the insurance industry, HMOs, Colorado Civil Rights Commission, etc.

The next meeting is scheduled at 5:30 p.m., Thursday, January 21,

1993, at CMS offices.

The **CMS Education and Research Foundation** will meet at 4:00 p.m. on Monday, December 7, 1992, at the offices of W. Gerald Rainer, MD, President. Agenda items will include proposed bylaws revisions, an update on student loan repayments, and ways to better promote CMS-ERF.

The **Organizational Study Committee** will meet at 4:00 p.m. on Tuesday, December 1, 1992, at the CMS offices. The committee will review and discuss a number of items referred to it by the House of Delegates and the Board of Directors.

Meetings of the **Coalition on Senior Issues** are scheduled at 2:00 p.m. at the CMS offices on the following dates:

December 15, 1992

March 16, 1993

June 15, 1993

September 21, 1993

December 15, 1993

The **Council on Professional Education** met November 19, 1992. Highlights of that meeting will be included in the January issue of C/M.

*In case you were unfamiliar with a particular Council or Committee, we have here provided some of the charges under which they operate.*

#### **Charge of the Council on Physician/Patient Advocacy**

The Council shall protect the integrity of traditional physician/patient relationships in an ever-changing environment in which third party

participants are assuming an increasing role. This Council shall identify and study current and new laws, regulations, and policies emanating from state and federal agents, intermediaries, peer review organizations (PRO), and private health insurers. The directives shall be monitored to determine compatibility with quality medical principles and CMS policy. The Council shall work with and respond on behalf of CMS members and their patients who require assistance in interacting with these agencies. Information shall be provided to members regarding the applicable laws, regulations and policies that impact the practice of medicine. Appropriate CMS policies with regard to these issues shall be recommended.

#### **Charge of the Medicare Advisory Committee**

Through the Medicare Advisory Committee there will be a body of physicians within the Colorado Medical Society that would be updated and current on the activities of Medicare. An educational process should be developed to inform members of changes as they occur. A compilation of local complaints should be made and the committee should be capable of communicating with the Colorado Carrier regarding any of these complaints and the impact of the policy on the physicians of Colorado. The Committee should monitor and develop a proactive stance with the local Health Care Financing Administration (HCFA) office. It should act as a

*Continues on following page...*



*For more information on any of these Councils, Committees or Sections, please don't hesitate to call the CMS at (303) 779-5455 or 1-800-654-5653 and ask for the appropriate staff person.*

sounding board for HCFA regarding new policies and projects that HCFA might implement and provide HCFA with information regarding what physicians' reactions might be. The Committee will also provide input on impending regulations.

#### **Charge of the Workers' Compensation Advisory Committee**

The Committee shall study current and new state laws, regulations and policies. The Committee will strive maintain fair physician reimbursement while ensuring that there is an adequate number of qualified physicians to provide quality care to the injured workers of Colorado. The Committee will promote open communication with the Division of Workers' Compensation, the State Insurance Commissioner, the State Compensation Insurance Fund, private insurance carriers that offer casualty insurance, or any agent thereof. The Committee will be involved in the Advisory Committee as established by the Department of Labor as well as all task forces and commissions. Members will provide testimony at any public hearing or meeting where changes are being recommended to any rule or regulation applicable to medical care. The Committee will educate the membership of all changes.

**Council on Legislation** will meet on the following dates at 4 pm in the offices of the Colorado Medical Society, 7800 E Dorado Pl in Greenwood Village. For directions, phone Suzanne Hamilton at (303) 779-5455 or 1-800-654-5653.

December 3, 1992, January 21, January 28, February 4, February 18, March 4, March 25, April 8, and April 28, 1993.

**Workers Compensation Advisory Committee** will meet January 6, February 10, March 3, May 12, June 2, July 7, August 4, September 1, October 6, November 3 and December 1, 1993. All meetings are at 7:30 am. For more information, contact Edie Register, Director of Health Care Financing at (303) 779-5455 or 1-800-654-5653.

The **Medicare Advisory Committee** will meet January 11, February 8, March 8, April 12, May 10, June 4, July 12, August 9, October 11, November 8 and December 13, 1993 at 6:30 pm. For more information, contact Edie Register, Director of Health Care Financing at (303) 779-5455 or 1-800-654-5653.

The **Physician/Patient Advocacy Council** will meet January 26, February 23, March 23, April 27, May 25, June 22, July 27, August 24, September 28, October 26 and November 23, 1993 at 6:30 pm. For more information, contact Edie Register, Director of Health Care Financing at (303) 779-5455 or 1-800-654-5653.

**Council on Legislation** will meet December 3, 1992, January 21, January 28, February 4, February 18, March 4, March 25, April 8 and April 29, 1993.

**NOTE:** Date subject to change due to unforeseen circumstances. If you plan to attend, call CMS to confirm the meeting.





# Mile High News

1992-1993 Vol. 6, Issue 2

Colorado Medical Society Auxiliary

December, 1992

## PRESIDENT'S MESSAGE

It is always a wonderful experience to attend the CMSA fall meeting. To bask in the beauty of the mountains, to hear of the innovative county programs, to attend the stimulating educational programs and to enjoy the company of friends at the fun-filled entertainment. This year was no exception. The CMS program "Limitations of Medical Care: Ethical Decision Making", was excellent and very timely. Our own suxilian, Kathy Dirks of Mesa County, gave us a sensitive and informative update on Sudden Infant Death Syndrome. Nurses attending these sessions received 7.5 hours of CEU credit. The AMA Auxiliary HAP award was presented to Mesa County at the CMS House of Delegates receiving a standing ovation from the House. Mary Hanson, AMAA president-elect and our national representative spoke to us about membership and leadership. She chalenged us to be "focused, flexible and farsighted" and also explained the AMA auxiliary goal of +1 for 1992-93. Our Colorado +1 goal is to have one more delegate at our national meeting in June 1993 to honor Mary at her installation as president of the American Medical Association Alliance. In order to accomplish this goal, we need an average of 10 additional members per county. I hope each one of you will encourage just one person to become a national member this year.

Each of you has an opportunity to do as much as you wish with your auxiliary membership. Some members can



only pay dues at this time in their lives. We are certainly grateful for your financial involvement and look forward to the time when you can join us in a more involved way. Others have time and energy to give and we hope you will let us know where you would like to be involved. As I told the CMS at the House of Delegates: "We believe the Medical Auxiliary should be a priority for all physicians' spouses, because of the unique relationship we have with our husbands and wives and with the

Medical Society. I also urged them to recognize that we are an important component of the health care partnership in Colorado and to "encourage your spouse and the spouses of your colleagues to become an active part of the Colorado Medical Society Auxiliary".

A motion was passed at the general membership meeting to change the name of the Auxiliary to "Colorado Medical Society Alliance" with a tagline "Physicians' spouses dedicated to the health of America. This requires a by-laws change which will be voted on at our House of Delegates Meeting in April. Please discuss this in your counties so that your delegates will be prepared to vote your wishes. Many Members feel that this change will reverse the decline in membership by appealing to our career and male spouse potential members.

I wish you all a wonderful Holiday Season and a prosperous New Year, and look forward to working with you in 1993!

*Pam Laman*

## WELL DONE—AWARDS

State AMA/ERF awards were presented at the CMSA general meeting in Copper Mountain to the following counties:

Largest Contribution per member:

1st LONGMONT

2nd LARIMER

Largest Contribution:

1st DENVER

2nd PUEBLO

ALICE SMITH AWARD ( LARGEST % INCREASE)

1ST LARIMER—94.4% increase

2nd MONTROSE—92.5% increase

## ARE YOU WONDERING...?

### COLORADO HEALTH CAREERS COUNCIL

As many of you know, the Colorado Medical Society Has withdrawn it's support from the Colorado Health Careers Council. For over 30 years, the two groups worked together successfully to provide a clearinghouse for health careers information in Colorado. In recent months, however, it has appeared to the CMS that the Council's policies have become "commercialized", moving away from the original intent of CMS when it founded CHCC. For this reason the CMS and the CMSA have decided to disassociate themselves from the Council.

*Carol Sides*

## LEADERSHIP CONFLUENCE '92 — THINK ABOUT IT...

*Joyce Markusfeld,  
President-Elect, Pueblo County*

Leadership. Commitment. Service. AIDS. Family violence. Friendship. These were some of the catchwords at the October Leadership Confluence in Chicago. Participants from all over the country each brought their unique perspective on what it is like to be a physician's spouse in the '90's.

In a community and in a world where needs seem to outnumber resources, we find ourselves long on enthusiasm and good intentions but short on time and energy.

One participant spoke with caring concern about "our medical family". I liked that phrase because I can relate to it. Like members of a family, each auxiliary tries to meet it's own needs and to be of service in it's own way, in it's own community. Like a family, we are related by circumstances, share common goals, problems and concerns. We help each other grow.

Confluence for me was an opportunity to learn, laugh, wonder, question, to be amazed, feel proud, and grow—like people do in good families...

## EMERGENCY BENEVOLENT FUND (do YOU know what it is?)

*Sharon Cunningham*

The Emergency Benevolent Fund was established in 1942. These funds are in a savings account at the First National Bank of Denver and are immediately available for financial assistance to members of the Colorado Medical Society Auxiliary, their spouses and minor children. It is funded by designated gifts and it's own re-invested accrued interest. Both the principal and interest may be disbursed at the discretion of the Emergency Benevolent Fund Committee.

The monies of the Emergency Benevolent Fund are available for emergency needs only and not for continuing assistance, except in rare cases. The only requirement for requesting assistance is that the need be financial and cannot be met from any other source. The committee has the sole discretion to designate the use of these funds and, once given, they are considered a gift to the recipient, with no requirement for reimbursement.

The Governing committee consists of the current CMSA President and the past three years' presidents. They serve three year terms.

Requests for assistance shall be in writing, presented to the committee by either the president of the applicant's county auxiliary, the state President or a member of the committee. A confidential investigation must be made by a committee of members in the requesting county and their recommendation presented to the EBF committee. Upon approval at the State level a check will be sent from the CMSA treasurer for the granted amount. These requests will be held in strict confidence and are recorded in the files as numbers only.



## CONFLUENCE WAS: ORGANIZED, DYNAMIC, MOTIVATING...

*Linda Silver,  
President-Elect, El Paso County*

We knew from the beginning that when we attended this meeting we would be trained to become better leaders in our organization. The sessions were well ORGANIZED with speakers who were energetic and very knowledgeable about what they communicate to us.

DYNAMIC. That is what AMAA is. My time was not wasted. To digest all that I heard and observed will take some time. I was MOTIVATED to come home and share ideas about how to involve more people at the county level. I want our members to know that they are appreciated and that, no matter how small the task they take on, it DOES count and does matter.

I am not a superwoman, but because of this Confluence, I feel I can make a positive difference in our organization.

## WERE YOU THERE?? METRO REGIONAL AUXILIARY MEETING

*Patti Brown,  
President, Denver County*

Mary Jane Newens, CMSA Regional Director, asked the Denver Medical Society Auxiliary to host the October Metro Auxiliary Meeting. In keeping with the Denver Auxiliary's emphasis on helping victims of Domestic Violence, Ruth Ann Russell, Executive Director of Safehouse, was the guest speaker. Ruth Ann brought a powerful message about the problem of battering. "The victims of domestic violence are all around you— your neighbor, friend, sister, co-worker, or your boss," says Ruth Ann. Batterer transcends socio-economic lines as well. Most of the area "Safehouse" beds are full and more women are seeking help. Finding places for them is a growing problem. Safehouse is working in alternative ways to help the victims escape their situations...through education, finding jobs, using area hotels, or even having the man removed from the home rather than uproot the woman and her children. She suggests that early intervention may stem the cycle of violence by removing the children from an environment they may come to view as "normal".

Ruth Ann thanked the auxiliaries for their interest in this problem, their generosity in the gifts and money



collected at the luncheon and asked for our continued support of Safehouse. With the holidays coming up, there are many items on the Safehouse Wishlist. (IF YOU CAN HELP— for a complete WISHLIST contact Patti Brown 794-1023 or Mary Jane Newens 320-1569 )

Forty-eight auxiliaries attended this informative meeting and most brought gifts for the residents of Safehouse. Mary Jane also arranged for a door prize ( a massage donated by Denver Auxiliary Anne Piccone), and a raffle of a dried flower arrangement ( donated by Denver Auxiliary Lois Rainer). Because of the generosity of the auxiliary members present, \$216 was also collected for Safehouse.

A big THANK YOU to Mary Jane Newens for a great speaker and to Ann Cook, Betty Howe and Trudy Peterson for planning the menu, decorations, reservations and all the other details that made this such a success.

## DENVER'S COMMUNITY SERVICE PROJECT

*Patti Brown,  
President, Denver County*

Because a woman is battered every 15 seconds in the United States and because battering kills as many American women every five years as Americans killed in the Viet Nam war—the Denver Medical Society Auxiliary wanted to reach the victims of battering in a non-threatening way and provide them with the information about where to get help in our community.

The DMSA wrote, produced (with the help of the Denver Medical Society and the OB/GYN Society) and distributed 50,000 pamphlets titled "No one Deserves to Be Hit". This small, easily hidden, pamphlet details services available to victims of domestic violence and is available in 420 Denver Doctors' offices. Written by DMSA auxiliary Connie Platt, it contains hard facts about domestic abuse and services available in the Metro area.

Specialties targeted by the distributing auxiliaries included Internal Medicine, Family Practice, OB/GYN, and Pediatric Physicians. Denver area Hospital Clinics also received the packets of 100 pamphlets. A letter included in the packets, from the DMS President Patti Brown, suggests that these pamphlets be placed in a private area in the office, where an abused patient might see the information and be able to pick it up and secret it on her person without being identified as needing it. The letter also offers an in-service training for physicians and staff by Connie Platt on domestic abuse, identifying symptoms and how to help.

These pamphlets have been warmly received by physician's and their staffs and Ms. Platt has received many calls to schedule training sessions and re-order pamphlets. She has also had requests to have a Spanish translation of the pamphlet. The DMSA is currently collecting funds to reprint the pamphlets and will do so as soon as the funds are there)

*(ed. note : Auxiliaries around the state might consider this a time to COLLABORATE/ CONTRIBUTE / DISTRIBUTE...*

## RIGHT IN OUR OWN BACKYARD— THE POWER OF OUTREACH

*Carol Michalek*

AS CMSA Project Care Chairperson, I have come to realize how much the Auxiliary does in the way of community outreach. Each County Auxiliary is very active in various community projects. I began to wonder how much time and energy are we able to give to our own families and to other medical families who might be in need of "outreach".

For the most part, I think medical families are healthy. However, there are those who live in a "conspiracy of silence". Others in the medical community participate in the conspiracy because our fears get in the way of approaching someone else when we are concerned with what we see happening in their family. Many fears keep us from asking ourselves or others if there is a problem. Fear of making changes, fear of the feeling of helplessness, and fear of shaking the image of what the "successful" physician and family should be, are just a few of the fears that get in our way.

Project Care and similar County Auxiliary Programs, can be instrumental in overcoming some of these fears and help auxiliaries to do some "outreach" with their own family and with fellow medical families.

Three Auxiliary programs come to mind to help address these issues:

- 1) EDUCATIONAL programs
- 2) FINANCIAL Support
- 3) SUPPORT Programs and PEER ASSISTANCE Programs

I would like to encourage CMSA and the County Auxiliaries to initiate or continue outreach programs to our own medical community. As Chairperson, I hope to do my part and to be available to participate on the county level in whatever way I can. Medical families are special. We need to be healthy within our own families, so we might continue being active and influential in our communities.

## SPEAKING OF OUTREACH...

Hurricane Andrew, in Florida and Hurricane Iniki, in Kauai, Hawaii devastated the medical communities. In Florida, an estimated 800 to 1000 physicians' families lost their homes and offices as a result of the storm and some may never recoup what they have lost. According to information received by the AMMA, all medical families on Kauai survived the hurricane safe and uninjured.

There have been many inquiries as to how we can help these families begin to rebuild their lives. The Florida Medical Association, in cooperation with the Dade County Medical Association, has set up a special fund to aid disaster victims. It is the HURRICANE DISASTER RELIEF FUND of the FLORIDA MEDICAL FOUNDATION, and contributions can be sent to the foundation at P.O. Box 2411, Jacksonville FL. 32203.

The HAWAII MEDICAL ASSOCIATION COMMUNITY RESEARCH BUREAU has established a special relief fund for residents affected by the hurricane. Contributions (tax deductible) may be mailed to : HMA Community Research Bureau 1360 S. Beretania St. Honolulu, HI 96814.

# County Presidents



*Patti Brown, President of the Denver Medical Society Auxiliary, also co-chairs Participation '92, the election action effort.*



*Colorado Springs resident Mary Lain is President of the El Paso County Medical Society Auxiliary.*



*Rosalie Schreiber managed to organize her life so effectively, that, in addition to her duties as President of Arapahoe County Auxiliary, she was also able to give birth to Kendra Schreiber, October 10.*



*Ginny Johnson and Patricia Grant, both of Fort Collins, co-chair the Larimer County Medical Society Alliance.*



*Clare Fowler and Cathy Rupp work together as co-chairs of the Longmont Auxiliary to the Boulder County Medical Society.*



*Lynette Wilz watches the helm as President of the Pueblo County Auxiliary*



*Carol Barbero is President of the Western Slope's Mesa County Medical Society Auxiliary.*

*Not pictured are: Wendy Weiner, Boulder; Diane Halley, Clear Creek; Emily Schneider, Montrose; Mary Yoder, Otero; and Carol Corona, Weld.*

## IS ANYBODY THERE?

*Susan Larkin*

I asked that question several months back—and bless the three people who responded...I ask it again for a new reason: This newsletter needs a new Editor.

For each of us there are not enough hours in the day to do what we NEED to do, much less all that we and our spouse and children WANT to do. As Joyce Markusfeld so aptly addresses it elsewhere in this missive: I am long on enthusiasm and good intentions but short on time and energy. As President, Pam Laman is "up to her ears in alligators" doing "Presidential" tasks to lead the Auxiliary: it is too much for her also to do another of the auxiliaries most important tasks: Let people KNOW what the AUXILIARY DOES—which is a LOT.

This is an interesting job, requiring 6-8 hours of your time every other month. Mike Thompson, of the CMS staff is MORE than helpful. The Macintosh you type this on does magic—and auxiliaries across the state DO send you the information and pictures. It is truly a dream job for someone who likes an independent, limited time commitment. For someone with the right computer software, you could even do it at home and send the disc to Mike at CMS!~

We all get here periodically: I am in overload and I need to move on! Please call Pam to tell her soon—I have already put some articles on the computer for you for the next issue...

## DATES TO REMEMBER

Winter Board Meeting January 20, 1993

Confluence II January 31-Feb. 2, 1993

Legislative Day Feb. 22, 1993

(Call Sharon Fowler NOW to HELP/Reservation!-719-545-2201)

CMSA House of Delegates April 2-3, 1993 (tentative)

AMAA Annual Meeting June 13-16, 1993

( Mary Hanson to be inaugurated!)





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The position becomes available in Spring 1993. Salary negotiable, ample vacation, excellent university benefits and paid malpractice insurance.

Interested physicians should contact Stephen O. Loyd, MD, Chief of Staff, Wardenburg Student Health Center, University of Colorado, Campus Box 119, Boulder, CO 80309-0119, (303) 492-5101. Closing date for applications: January 30, 1993 or until positions are filled. The University of Colorado at Boulder has a strong institutional commitment to the principle of diversity in all areas. In that spirit, we are particularly interested in receiving applications from a broad spectrum of people, including women, members of ethnic minorities and disabled individuals.

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## RUMINATIONS

(def: to chew again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

### *Presence of mind versus the barrel of bricks.*



April 4, 1980

Dean White Enterprises  
Drawer 445  
Iola, KS 66749

Dear Sir:

I am writing in response to your request for additional information. In block number 3 of the accident reporting form, I put quote --poor planning-- unquote, as the cause of my accident. You said in your letter that I should explain more fully, and I trust that the following details will be sufficient.

I am a bricklayer by trade. On the day of my accident, I was working alone on the roof of a new six-story building. When I completed my work I discovered that I had about 500 pounds of bricks left over. Rather than carry the bricks down by hand, I decided to lower them in a barrel by using a pulley which fortunately was attached to the side of the building, at the sixth floor.

Securing the rope at ground level, I went up to the roof, swung the barrel out, and loaded the brick into it. Then I went back to the ground and untied the rope, holding it tightly to insure a slow descent of the 500 pounds of brick. You will note in block number eleven of the accident report form that I weigh 135 pounds.

Due to my surprise at being jerked off the ground so suddenly, I lost my presence of mind and forgot to let go of the rope. Needless to say, I proceeded at a rather rapid rate up the side of the building.

In the vicinity of the third floor, I met the barrel coming down. This explains the fractured skull and broken collarbone.

Slowed only slightly, I continued my rapid ascent, not stopping until the fingers of my right hand were two-knuckles deep into the pulley.

Fortunately, by this time I had regained my presence of mind and was able to hold tightly to the rope in spite of my pain.

At approximately the same time, however, the barrel of bricks hit the ground--and the bottom fell out of the barrel. Devoid of the weight of the bricks, the barrel now weighed approximately fifty pounds.

I refer you again to my weight in block number eleven. As you might imagine, I began a rapid descent down the side of the building.

In the vicinity of the third floor, I met the barrel coming up. This accounts for the two fractured ankles and the lacerations of my legs and lower body.

The encounter with the barrel slowed me enough to lessen my injuries when I fell onto the pile of bricks and, fortunately, only three vertebrae were cracked.

I am sorry to report, however, that as I lay there on the bricks--in pain, unable to stand, and watching the empty barrel six stories above me--I again lost my presence of mind--**I LET GO OF THE ROPE.**

1840











